

# *The Modern Hospital*

APRIL 1958

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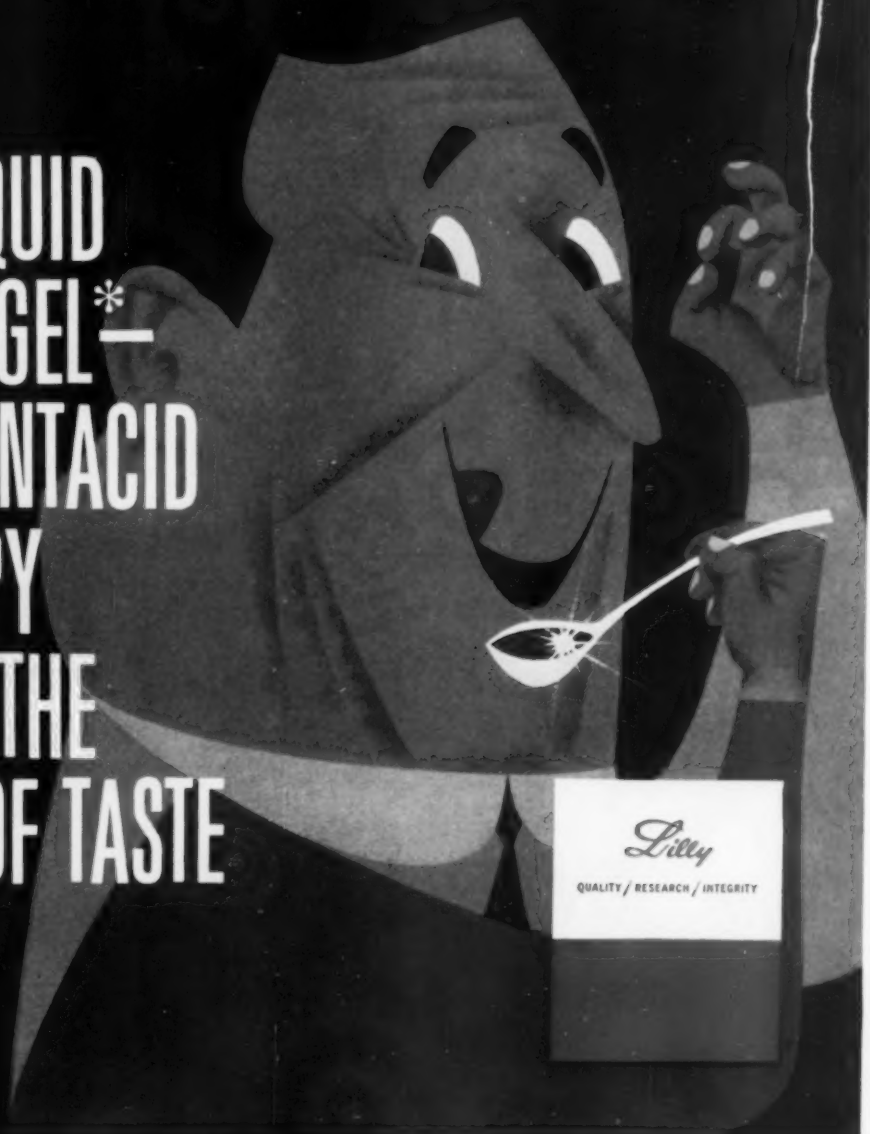
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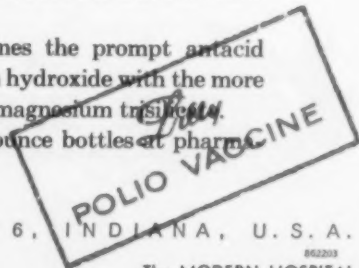
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The MODERN HOSPITAL

# The Modern Hospital

APRIL 1958

VOLUME 90, NO. 4

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### You Know What You Mean—But Who Else Does?

S. G. HILL

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# The Modern Hospital

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## READER OPINION

### Architect's Name Omitted

Sirs:

I was simply amazed to read in the February 1958 issue of The MODERN HOSPITAL magazine, the article "Community Hospital Adds a Long-Term Unit," which is a four-page article with pictures of the Merwick Home which we did at the Princeton Hos-

pital. My amazement is the complete lack anywhere in the article of the mention of the architect's name or his part in the program. My amazement is more pronounced in that I know that your people must have known that we were the architects for the building—both from contact with Mr. Kauffman at the hospital and because James Connolly, who handles our pub-

lic relations, has been in touch with your editors in connection with this particular project—such contact, as we understand it, going back several months.

I realize that most of Mr. Sloan's article was probably obtained through the public relations department of the Princeton Hospital, and while they may not have stressed or realized that it is customary to give the architect credit in using his material, your people certainly must know better. I further feel that if you retreat to the fact that you did not know that we were the architects, that your people should have made it their business to find out who were the architects.

It seems to me that your magazine must depend considerably on architects—not only to furnish material and pictures, but that we often spend considerable time in preparing suitable material for the magazine. It appears to us that the least you can do for us is to give us credit when you use projects which are designed by architects. It would almost seem as though such credit is a matter of common courtesy.

I feel justified in asking that your magazine carry in a forthcoming issue a statement to the effect that our name was inadvertently omitted from this article and that we were its architect. Under the circumstances I do not believe that such a notice should be placed amongst the advertising in the magazine.

The article seems to have been of sufficient importance even to make your cover.

Aaron N. Kiff

Kiff, Colean, Voss & Souder  
Architects  
The Office of York & Sawyer  
New York

*"It is good that we suffer sometime contradiction, and that we be holden of others as evil and wretched and sinful, though we do intend well, for such things help us to meekness, and mightily defend us from vainglory and pride."—The Imitation of Christ. —Ed.*

## These Hospitals All Use **SUREPOWER** Generator Sets for Protection

All of the hospitals at the Medical Center in Columbus, Ohio, use Allis-Chalmers engine generator sets to "bridge" external power failures and electrical service interruptions — instantly, dependably.

Experience with their unfailing performance prompted the hospital directors to install additional Allis-Chalmers units as facilities were expanded.

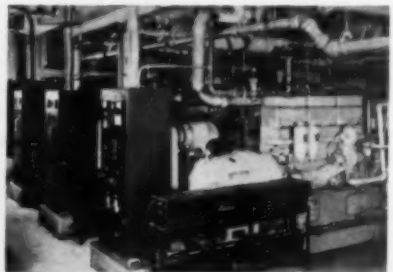
**All Fuels, Many Models—** Allis-Chalmers engines operate on fuels available locally — gasoline, LP or natural gas, or diesel fuel. Generator capacities are from 5 to 300 kw, DC or AC current, single or three-phase, 50 or 60 cycles, and a range of voltages.

**A Single Source** means undivided responsibility for the entire set. Allis-Chalmers engineering, precision manufacturing and careful matching of electrical equipment and engines assure reliability—simplify maintenance.

Consult your Allis-Chalmers engine dealer... whether you are protecting existing facilities or expanding. He will make sound



Four 125-kw Allis-Chalmers Model 6DC5G-1879 engine generator sets provide standby power at the Ohio State University Medical Center. Another larger unit is being added to protect new facilities.



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# ALLIS-CHALMERS



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Before you send to the binders your copies of the 1957 issues of The Modern Hospital, you will want a copy of the index to each volume. The index to Volume 88 was bound into the June issue. The index to Volume 89 (July to December) may be obtained by addressing a postcard or letter requesting a copy to The Editor, The Modern Hospital, 919 North Michigan Avenue, Chicago 11, Ill. There is no charge.



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# ROVING REPORTER

## Hoping You Are the Same

I was confined to the hospital recently. I was unaware that all of the old-fashioned sentiments of sympathy, good will, and condolence had been appropriated by greeting card manufacturers and are now properly expressed by multiple-fold billets with merry quips, puns from dubious sources, and slightly indecent suggestions.

It was not until I began to recuperate from the inundation of these modern cards that I realized there was no way to acknowledge in kind these printed insults. But now, as a result of much card reading and research, I have undertaken to remedy this unhappy situation by offering to all greeting card makers, postage prepaid, some samples with which they can go to work.

## Appendix

*Thanks, thanks to thee, my worthy friend*

*Your message was a pickup  
Although they say I'm on the mend  
It gave me quite a hiccup.*

## Zipper Type

*Your kind words made me feel real high  
And cured my painful ache.  
I haven't felt so good since I  
Was opened by mistake.*

## Monkey Business

*'Tis true I've lost a favorite gland.  
'Twas useless, anyhow.  
You will be pleased to understand  
I'm far from prostate, now.*

## Invitation

*Your card was like a birthday cake  
And caused a sticky grin.  
I'm in Room 30, by the lake;  
I hope, friend, you'll drop in.*

Frederick J. Moffitt

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QUALITY**

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## Nurses Take Refresher Course

An attempt by the Veterans Administration and Illinois nurses' groups to solve the registered nurse shortage in Chicago has resulted in the return of 12 nurses into the nursing field.

The 12 nurses, ranging in age from 33 to 65, have completed a four-week refresher course at the Chicago V.A. West Side Hospital.

"The lack of refresher courses seems to be part of the answer as to why nurses haven't returned to their profession," said Janice S. Woram, chief of nursing service at the V.A. hospital and president of the Chicago Northeastern League for Nursing.

"Nurses who have been away from nursing for any length of time are apprehensive about returning without a brushup on new techniques," she declared.

Miss Woram said a nurse who has been away from duty for a few years feels the need for classroom instruction combined with supervised work on the wards.

The 12 nurses, some of whom haven't practiced their profession for 20 years, received two hours of classroom instruction and four hours of hospital experience each day during the four-week course.

They would be permitted to application for employment with the Veterans Administration or elsewhere when the training was completed, Miss Woram said.

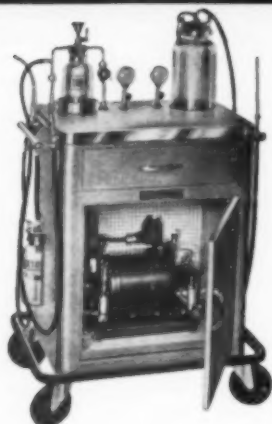
Two other Chicago hospitals are prepared to give similar courses if this V.A. pilot effort works satisfactorily, the agency reported.

Nurse groups cooperating in the

The MODERN HOSPITAL

# IMPROVED

## ... SKLAR-BUILT SUCTION AND PRESSURE UNITS

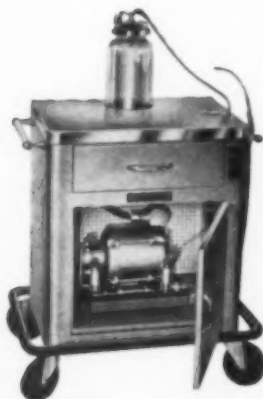


\*Improved motor assembly and simplified electrical installation result in lower manufacturing costs which are reflected favorably in the prices of these new models.

These suction and anesthesia units are totally explosion proof and approved by Underwriters' Laboratories, Inc. for use in Class 1, Group C hazardous locations. All tubing, casters and bumpers on the Bellevue and Printz models are of conductive rubber. Motor units are rubber mounted, minimizing vibration. Cabinets are insulated with Celotex to insure noiseless operation.

### NEW IMPROVED BELLEVUE MODEL, CAT. No. 100-75.

Now equipped with 32-ounce suction bottle for the exclusive use of the anesthetist in addition to the regular 1-gallon suction bottle and 32-ounce ether bottle.



### NEW IMPROVED PRINTZ MODEL SUCTION UNIT, CAT. No. 100-80.

Equipped with 1-gallon suction bottle and recessed suction gauge. *Printz* Model, Cat. No. 100-85 (not illustrated) has a 32-ounce ether bottle in addition to the 1-gallon suction bottle.

*Printz* Model, Cat. No. 100-87 (not illustrated) is same as 100-85 but equipped with separate rotary compressors for ether bottle and suction bottle.



### NEW IMPROVED TOMPKINS MODEL SUCTION AND ANESTHESIA UNIT, CAT. No. 100-10.

Complete with 32-ounce suction bottle, 16-ounce ether bottle, two-way by-pass valve and spray tube. Sklar Pump Table, Cat. No. 100-40 (not illustrated) mounted on conductive rubber casters, complete with utility drawer, shelf and rack for sprays and sinus cleanser. Tompkins Model for suction only, Cat. No. 100-15 (not illustrated) is equipped with two 32-ounce suction bottles and no ether bottle.

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DESCRIPTIVE LITERATURE ON REQUEST



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LONG ISLAND CITY, N. Y.

Sklar Equipment is available through accredited surgical supply distributors.

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*Diack Controls*

## IN TODAY'S MAIL

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On opening the box we were quick to see that the controls were *not ours* but of another manufacture.

There are several makes of sterilization controls on the market today, which may outwardly appear to be Diacks.

However, only one genuine Diack is of Smith & Underwood manufacture. The name **DIACK** is plainly stamped on our box of controls.



SMITH & UNDERWOOD, Royal Oak, Michigan . . . Sole manufacturers of Diack Controls and Inform Controls

program include the Illinois League for Nursing, State Nurses Association, Chicago Council on Community Nursing, and the Committee on Careers in Nursing.

### Patient Waits on Steps

The first patient at the new Clara Maass Memorial Hospital at Newark, N. J., waited on the steps for the doors to open.

Patients were being transferred in three convoys from the old hospital in Newark to new facilities 3½ miles away. When the admitting clerk arrived at the new \$5 million building, she found Mrs. Manuel Nunes sitting on the front steps in labor. A maintenance man arrived with a key to the boiler room and Mrs. Nunes was led to the fourth floor maternity ward. Several minutes later staff members were on hand to deliver a 5 pound 12 ounce girl.

### Coffee Break at 6 a.m.

The most refreshing pause in the day, say the new mothers at Bishop Clarkson Memorial Hospital, Omaha, Neb., comes at 6 o'clock in the morning.

That's the time the night nurse serves them a pre-dawn cup of steaming coffee.

Previously, the new mothers had spent a long hour waiting from 6 a.m.,



Mrs. John R. Alden looks pleased and grateful as she is served her cup of steaming coffee at 6 a.m. by the night nurse in the maternity ward at Bishop Clarkson Memorial Hospital.

when they had finished giving their babies their first feeding, until 7 o'clock, when their own breakfast trays finally arrived.

Now that void is filled by the coffee-break, thanks to Vivian Fiala, nurse supervisor of the obstetrics ward, who originated the idea. The early service is not inconvenient for hospital personnel, and the food service director has no objection, Mrs. Fiala says.

### Disabled Vet Blows Glass

Back in 1948, when a Veterans Administration counselor was trying to find a suitable training course for seriously disabled Adam Kolasa, the suggestion of glass blowing came up.

Today, Adam Kolasa of Irondequoit, near Rochester, N.Y., is skilled in one of America's little known trades—blowing delicate glass hydrometers.

Before World War II, Adam was a lens molder in a Rochester factory. Then, as a marine corporal in 1945, he landed on Iwo Jima. A bullet shattered his knee, two others ripped into his thigh. A mortar shell smashed into his litter group and the fragments tore the same leg in two more places.

It was 27 months before he was able to walk again, even with the aid of crutches.

After discharge he couldn't stand long enough to handle his old job as a lens molder.

V.A. advisers gave him aptitude tests. The glass blowing suggestion popped up and Adam liked it.

For four years he trained under the U.S. Vocational Rehabilitation Act as an apprentice in a small glass apparatus factory. However, the factory moved away, leaving him jobless shortly after he had attained journeyman status.

Then he found a place with a company in Rochester, this time as a combination glass blower and glass lathe operator. He blows delicate glass hydrometers into their peculiar gooseneck shapes and then fuses and finishes them on his glass lathe.

### Reduce Costs, Win Money

An employee at Aultman Hospital, Canton, Ohio, will be \$100 richer shortly after May 1, as the result of a hospitalwide contest to find the "most adoptable idea" to reduce costs. Suggestions submitted through the hospital's regular Idea Suggestion System and adopted by the hospital are in the running for the \$100 grand prize, in addition to the usual reward given each employee who submits an adopted idea.

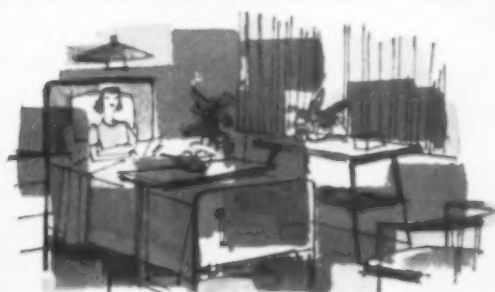
The contest began last year, and all suggestions used by the hospital between July 1, 1957, and May 1 of this year are eligible for the grand award.

According to the *Aultman Trailblazer*, suggestions are rated on the following factors:

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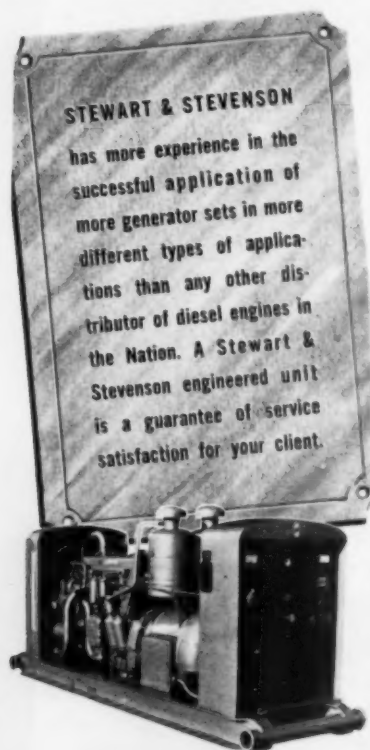


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## Public Relations

### People Who Talk Same Language Have No Need for an Interpreter

BY GORDON DAVIS

MY FRIEND, the City Editor, arrived for our luncheon date with the whites of his eyes showing like those of a wild stallion at the first taste of the bit.

"I need a drink," he gasped as he dropped into the chair I had reserved for him.

"What was it?" I inquired. "A big fire? A plane crash? A maniac running amok?"

"Hah!" he snorted. "When did you ever see me disturbed by a mere disaster? No, heaven help me! This morning I spoke before the publicity representatives of the Amalgamated Women's Clubs."\*

"Of your own free will?" I queried.

"No," he admitted. "The editor made me."

"What did you tell them?"

"I told them I wished the word 'publicity' had never been invented. I told them that the newspapers do not exist to print publicity, but to print news. I told them to quit thinking in terms of publicity and to start thinking about how to help the newspapers do a better job of reporting their newsworthy activities."

"Sounds reasonable," I allowed.

"It's just the facts of life," he said bitterly, "but the ladies practically froze me off the podium. The next speaker was a gal who told them that the way to 'get publicity' was to demand their rights and bombard the papers with telephone calls and handouts. She was very nice in the way she said it, but she left no doubt about her opinion that the newspapers could do a lot better job of running their own business."

"On the other hand," I interrupted, "shouldn't the newspapers make some effort to understand the problems and needs of community groups like the women's clubs?"

"Look," he protested. "I don't want anything from the women's clubs. They want something from me."

"That's how wars begin," I commented. "Each side insists the other doesn't understand its problems."

"All right, wise guy!" he exploded. "You get paid to be a courier between groups with different interests. I don't. I get paid to put out a newspaper."

"You have hit exactly upon a primary public relations function," I agreed. "People who talk the same language have no need of interpreters. But you forget that the first newspapers were basically gossip sheets loaded with the kind of trivia that you now resent."

"So what? Do you want to turn back the clock two centuries?"

"So that's why we have public relations people," I said. "Because times change and specialization increases and there has to be someone to keep insisting on the similarities of human interests rather than their differences. Believe me, it's a fascinating job."

"Oh, yeah," he said, eyeing me skeptically. "I was going to say I needed another drink. On second thought, I think you need it worse than I do."



Gordon Davis

\*This is an actual case, but names and circumstances have been altered to protect the guilty parties.

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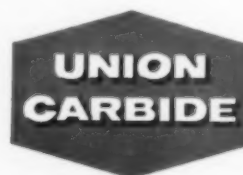
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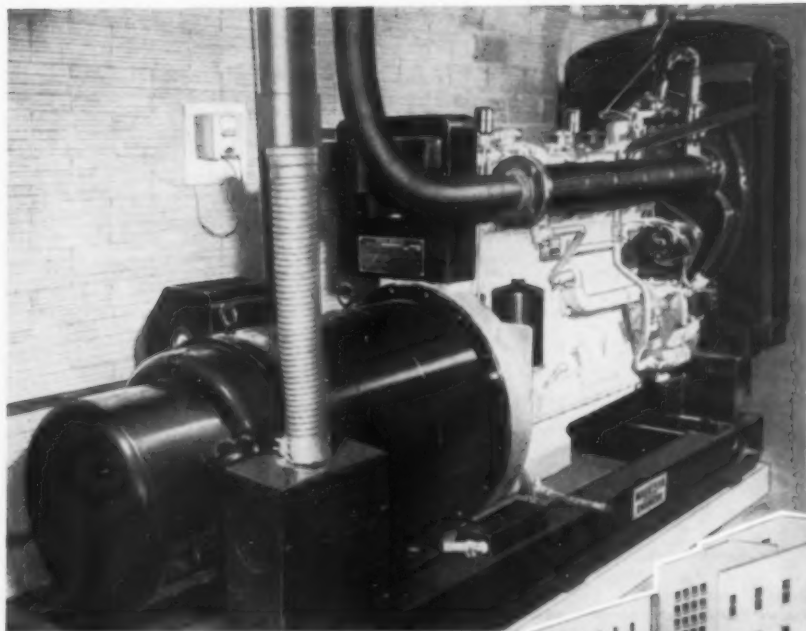
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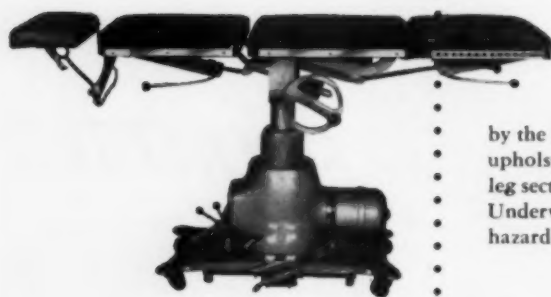
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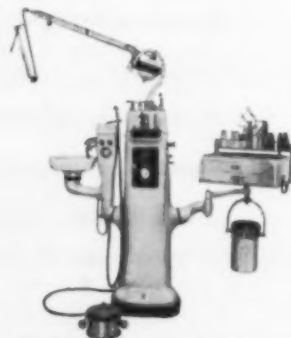
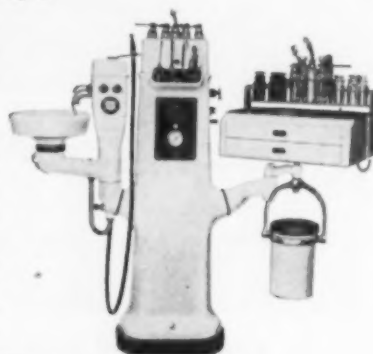


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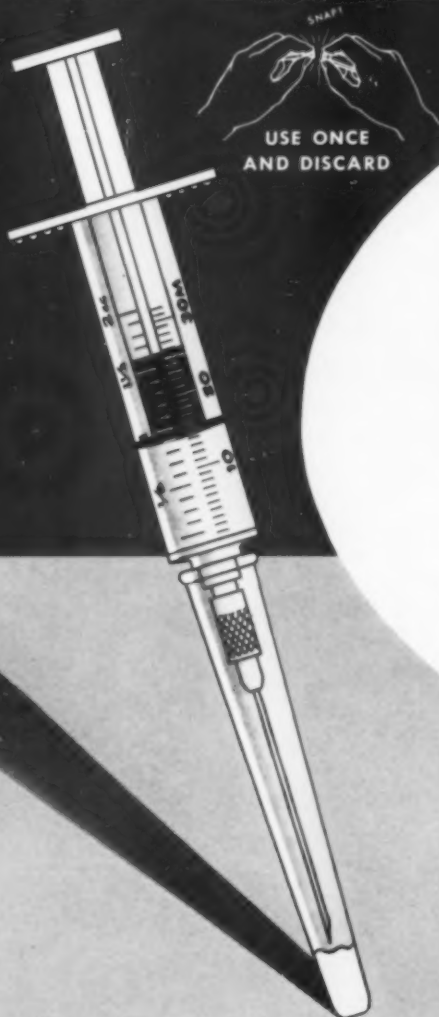


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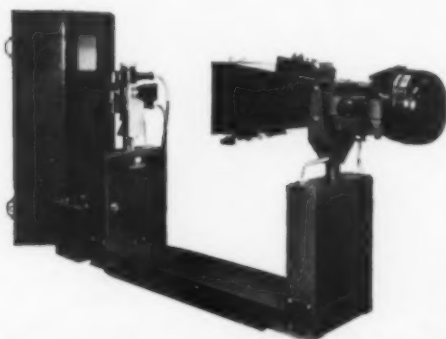
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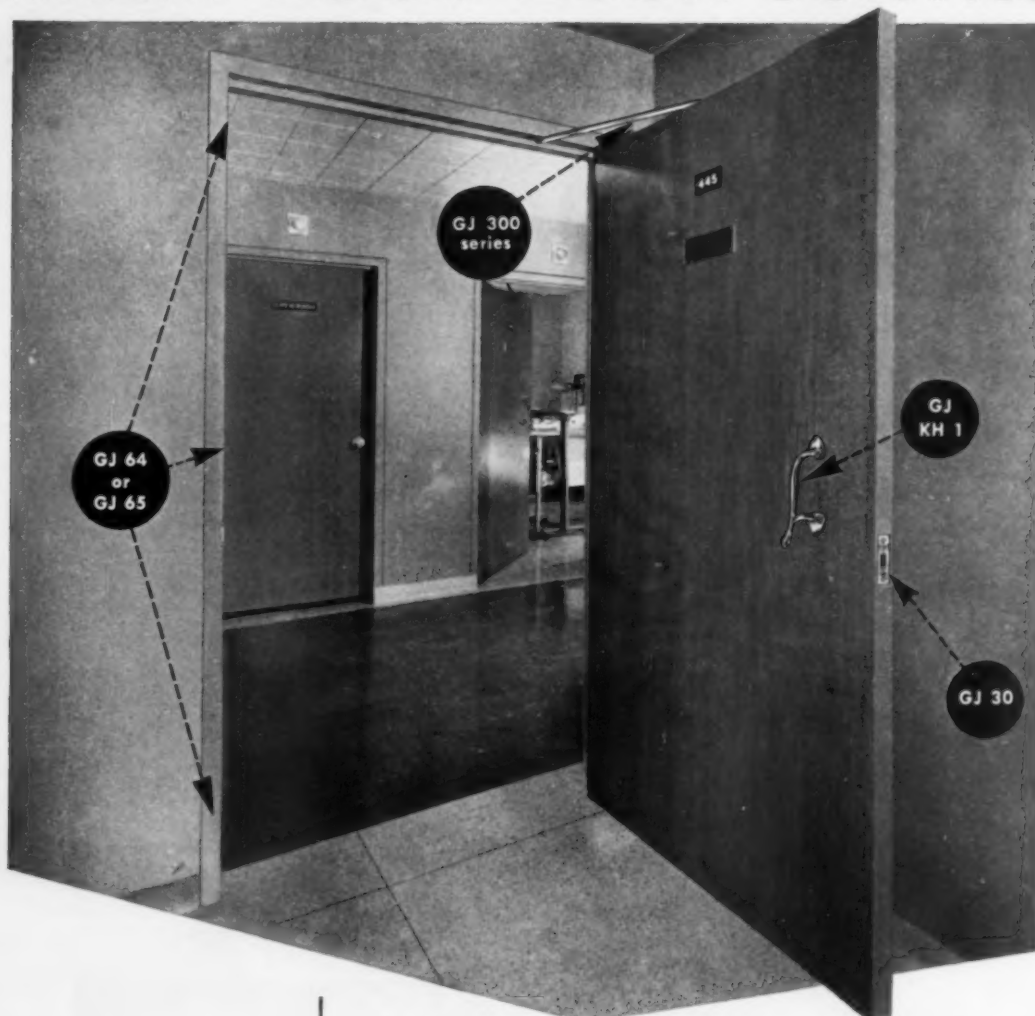
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*All above hardware can be quickly installed on existing patient room doors.*

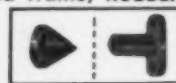
## **"shall have GLYNN-JOHNSON . . .**

**GJ 300 series CONCEALED (or surface mounted) OVERHEAD FRICTION TYPE DOOR HOLDER."** (Nurse may set door at any desired degree of opening for ventilation or privacy. Door cannot slam open or shut.)

**"GJ KH 1 COMBINATION HAND AND ARM PULLS to be mounted back to back as a pair."** (Convenient for opening door from either side with sterile hands or when carrying loaded trays.)

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**"THREE GJ 64 for metal frame (or GJ 65 for wood frame) RUBBER SILENCERS."** (Form pneumatic air pockets to absorb shock or noise of closing and create constant latch tension . . . no door rattling.)



write for HOSPITAL DOOR CONTROL brochure E-4

**GLYNN-JOHNSON CORPORATION**

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chicago 40, illinois

## NEW SELF-CLOSING *Ropeless* LAUNDRY BAG



**Saves hospitals thousands of dollars a year  
in bag maintenance and replacement costs**

No ropes or tapes! No grommets, eyelets, or drawstrings of any kind!

By eliminating these elements, Hartford Self-closing Ropeless Bags are saving hospitals and other institutions thousands of dollars a year. Sorters no longer have to struggle with knots, cut ropes, or repair torn grommets. Less drying time required, too. The bag dries uniformly without wet areas that rot and rip. Completely lock-stitched construction, reinforced corners, and unique pocket-type handles that can't pull off make Hartford Self-closing Ropeless Bags the toughest of their kind — anywhere! Result: you save both money and labor.

Find out how these extraordinary new bags can simplify your linen handling problems from the sick room to the sorter's table. For details, ask your dealer or write:



Bag slips easily onto hamper or over back of chair. Full flap seals in all linen; prevents spilling, reduces cross-infection.



Full-width opening lets linen fall out freely without tugging. No knots to untie — no ropes or grommets to tear and mend.

*Ask your dealer about our FREE HAMPER STAND OFFER!*

# **The Hartford Company**

22 Thomas Street • East Hartford, Connecticut



*Here's the Soap that's*  
**TAILOR-MADE FOR HOSPITAL USE!**



*The Soap You'll LIKE BEST!*

We asked hospitals—just like yours—what features you would suggest for the *perfect* toilet soap. You said you wanted specially sized cakes . . . a special fragrance . . . a hard-milled *economical* soap. And here it is—Colgate's BEAUTY WHITE! The soap you'll like best . . . because you helped us create it. Make your next order BEAUTY WHITE. Your patients will appreciate it—and you'll *save money!*

For Your Convenience . . . two sizes packed unwrapped.

Also one size available wrapped.

- ★ FINEST QUALITY SOAP ★ GIVES ABUNDANT LATHER IN ALL TYPES OF WATER ★ UTMOST IN ECONOMY
- ★ SAME BASE—SAME PLEASING FRAGRANCE—AS COLGATE'S FLOATING SOAP



**And For Your Private Pavilion—**  
 Mild and Gentle Palmolive Soap in its famous green wrapper. Quick lathering, meets highest hospital standards for purity, mild and easy on the skin. Write for sizes and prices.



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**ELECTRIC HOSPITAL BED**

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PALMER HOUSE, ROOM 787



**THE BED WITH 8 DISTINCT  
MOTORIZING ACTIONS**

DESIGNED AND PRODUCED BY  
**AMERICAN METAL PRODUCTS COMPANY**

DETROIT 4 **amp**® MICHIGAN

now ready for you...S-1501

# SURG-A-MATIC BY SHAMPAINE

The SURG-A-MATIC—A new concept in major operating table design—a product of Shampaine Research.

In every detail of SURG-A-MATIC, you see professional knowledge of operating room requirements and advanced surgical techniques.

SURG-A-MATIC—The table of tomorrow, here today... with many features that set new standards for major operating tables.

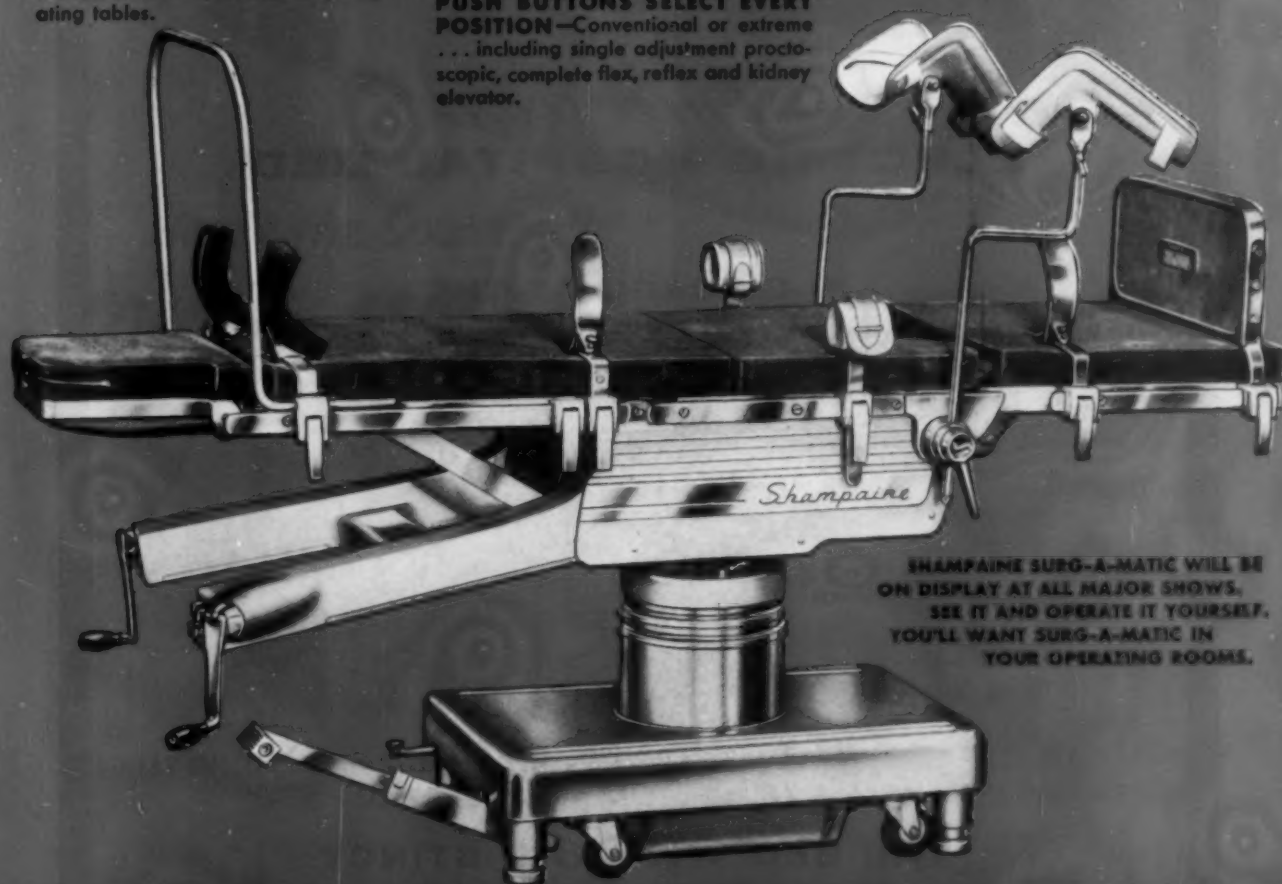
**TRUE HEAD-END CONTROL**—All controls face the anesthetist... outside the draped and aseptic areas. Anesthetist remains seated at all times. No search at the sides of the table to check indicators or reach controls.

**PUSH-BUTTON SHIFT**—A Shampaine exclusive! Ultra-convenient push buttons select all positions. Push buttons eliminate visual attention.

**PUSH BUTTONS SELECT EVERY POSITION**—Conventional or extreme... including single adjustment proctoscopic, complete flex, reflex and kidney elevator.

**NEW BASES**—Motorized or hydraulic... with new features for smoother, easier operation. No external housings (see details below).

**FAST ACTING SIDERAIL CLAMPS**—Eliminate broken or easy-to-lose set-screws. Accessories attached or detached with minimum effort and time.

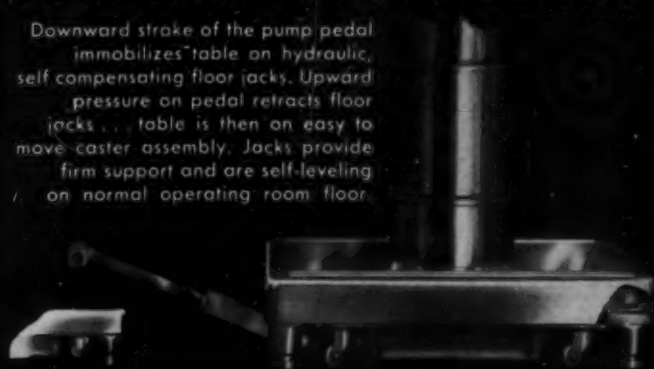


SHAMPAINE SURG-A-MATIC WILL BE ON DISPLAY AT ALL MAJOR SHOWS. SEE IT AND OPERATE IT YOURSELF. YOU'LL WANT SURG-A-MATIC IN YOUR OPERATING ROOMS.

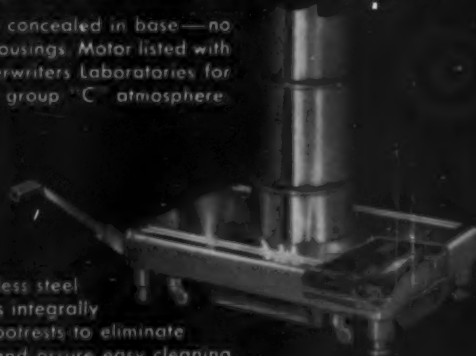
## NEW BASES... MOTORIZED OR HYDRAULIC...

Downward stroke of the pump pedal immobilizes table on hydraulic, self compensating floor jacks. Upward pressure on pedal retracts floor jacks... table is then on easy to move castor assembly. Jacks provide firm support and are self-leveling on normal operating room floor.

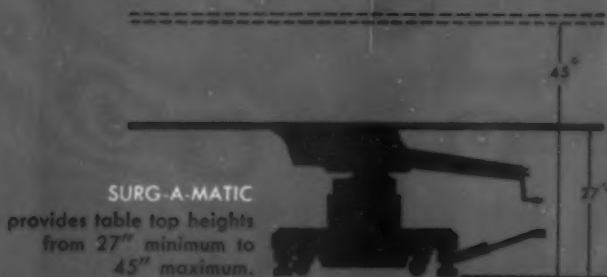
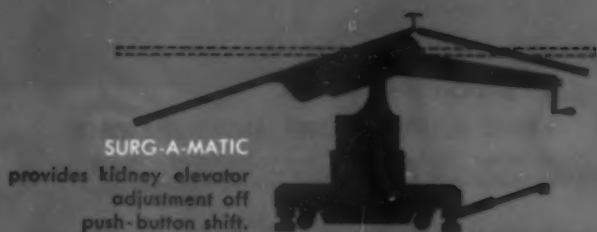
Motor concealed in base—no external housings. Motor listed with Underwriters Laboratories for Class "I" group "C" atmosphere.



Flat stainless steel shield has integrally formed footrests to eliminate crevices and assure easy cleaning.



# the all-new major operating table with push-button shift



JUST PUSH A BUTTON AND TURN HANDLE AT RIGHT TO REACH ANY OPERATIVE POSITION. Left handle controls independent Trendelenburg adjustments (maximum Trendelenburg in 22 turns). See new Shampaine positions at left.

Table top is supported by three widely spaced rods within the telescoping pedestal. They provide maximum lateral support to prevent shaking. Design eliminates need for exposed keyways.

Adjustable length on reversible foot pedal.



## Shampaine

COMPANY

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a SHAMPAINE  Industry

I told you our  
reputation would rise  
by specifying  
T & S Pedal Valves!

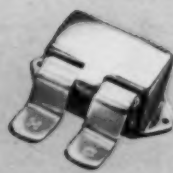


## PEDAL VALVES and SERVICE FITTINGS

Take the right step to fast, sanitary  
water dispensing. Specify modern  
T & S "stream-mated," streamlined  
Pedal Valve systems. Companion  
units available for hospitals,  
institutions, and food service areas.

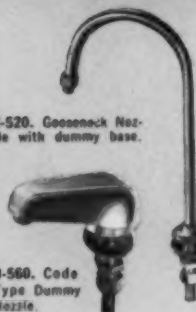
*Sanitary Water Flow*  
... AT THE TOUCH OF A TOE!

**B-503.** Combination  
Pedal Mixing  
Valve for hot and  
cold mixing.



**B-502.**  
Double Pedal  
Valve for  
hot and cold

**B-520.** Gooseneck Noz-  
zle with dummy base.



**B-560.** Code  
Type Dummy  
Nozzle.



### BED PAN WASHER AND GENERAL UTILITY SPRAY

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Many general uses for hot or cold  
"water-scouring."



See your local dealer or write direct  
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America's Most "Flexible" Line of Water Food Equipment! Pre-Rinse • Glass Fillers  
Water Stations • Faucets • Pedal Valves & Service Fittings • Spray Hoses • Accessories

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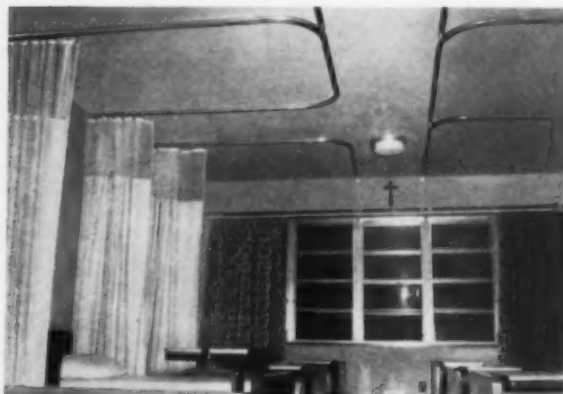


This is the  
new exclusive  
"NON-CONTACT"  
NYLON ROLLER  
now on every  
ARNCO Cubicle

You get free "finger-tip" operation regardless  
of the curtain length.

No sliding or locking when curtain is drawn from stacked  
position with this new carrier. The rollers really roll . . .  
and go around corners with ease.

**ARNCO HEAVY EXTRUDED ALUMINUM TRACK**  
exclusively for hospital use may be installed with either  
plaster or acoustic ceilings, with surface or flush constructions.



Ceiling type illustrated, although suspended type may be obtained  
where desired.

ARNCO CURTAIN CUBICLES designed exclusively for  
hospital's are completely unobtrusive . . . do not conflict  
with wall fixtures or lighting . . . completely eliminate  
interference with doors or windows. Their specially designed  
curtains provide ventilation as well as privacy. May be  
flame-proofed, if desired.

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The MODERN HOSPITAL



*Tile by Amtico*

## Now... a basic improvement in upholstered furniture ... with COMFORTORC construction

Now Simmons presents a revolutionary improvement in upholstered furniture. It's the new Simmons line—with entirely different, entirely new features that assure greater seating comfort, greater durability.

**exclusive:** The Comfortorc principle—special concealed torque springs for positive pitch of the sofa or chair seat—assures maximum comfort for persons of every weight. No conventional seat cushion can provide this self-adjusting feature.

**exclusive:** A new concept of durability! Comfortorc furniture frames are reinforced with angle steel to make them strongest on the market. Steel grids support the Beautyrest® cushioning.

Simmons upholstered furniture brings new beauty and comfort to lobbies, waiting rooms, reception rooms and other public seating areas. Just sit on this revolutionary furniture—then you really appreciate its wonderful new comfort. See it now at your Simmons display room—or write for descriptive catalog.

What's new  
about new Simmons upholstered furniture?



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# ONE DROP works wonders!

## Completely neutralizes any odor in seconds



### NOT JUST A "MASK"

but a magic odor-neutralizer that leaves a pleasant aroma which quickly disappears.

### ECONOMICAL

because it is highly concentrated. A single drop will deodorize an average room for 24 hours. Outlasts all conventional deodorizers.

### NON-TOXIC

and absolutely safe for all normal hospital routine.

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CONCENTRATED DEODORIZER

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**guaranteed  
sterile**

**Patient-Ready dressings**

Packages for Johnson & Johnson sterile hospital dressings are sealed by an exclusive research-designed process that actually welds paper together. No weak spots — no channels for bacteria to enter. Patient-Ready dressings stay sterile until you break the seal!

ACHIEVED through research

PACKAGED by modern equipment

STERILIZED with advanced techniques

MAINTAINED by continuous testing

*Johnson & Johnson*

PRE-WRAPPED,  
STERILE,  
PATIENT-READY



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**Steripak<sup>®</sup> Non-Adhering Dressing**

- *A unique dressing for minimal drainage wounds.*
- *Absorbent pad, faced with non-adhering perforated film.*
- *Super-Stick adhesive, vented for maximum aeration, holds dressing firmly in place.*

THE MOST TRUSTED NAME IN STERILE SURGICAL DRESSINGS

**Johnson & Johnson**

**ACME VISIBLE**

# FOR DOCTOR'S ORDERS

(medication and treatment)

**NEW ALUMINUM POCKET FRAMES TRAY TYPE,**  
with flanges on each side for rigidity.

**EASY TO USE.** Pockets with metal hinges permanently attached are suspended from individual metal card hangers. Any card may be removed without disturbing the hanger or other pockets . . . or pocket and hanger may be removed together and others shifted up or down to reinsert the pocket for a new record in proper sequence.



**WON'T SLIP...**  
ribbed rubber strips on back  
prevent slipping or scratching  
desk top . . . QUIET!

**LASTS LONGER.** Kraft pockets have  $\frac{1}{8}$ " acetate tip . . . larger, heavier materials for longer service and less frequent replacement.

**PRINTED RECORD FORMS . . .** Acme has a wide assortment of forms in stock or special design. Ask for samples to select the specific record card you prefer.

Services of experienced field representatives and our Hospital Systems Department are available to analyze your requirements and to recommend the most practical system, method or procedure. No obligation.

**ACME VISIBLE RECORDS, INC.**  
CROZET, VIRGINIA

## 4 SIZES

Card Size	Capacity	Item No.
6 x 4" cards	24	AT-HP-6411
6 x 4" cards	40	AT-HP-6415
8 x 5" cards	20	AT-HP-8511
8 x 5" cards	36	AT-HP-8515

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**ACME VISIBLE RECORDS, INC. CROZET, VIRGINIA**

Please send us booklet

☐ #971 Acme Tray Cabinets & Card Books

☐ #997 Hospital Record Efficiency ☐ #975 Acme Flexoline Catalog

☐ Have representative call. Date \_\_\_\_\_ Time \_\_\_\_\_

☐ We are interested in Acme Visible Equipment for \_\_\_\_\_ records.  
kind of record \_\_\_\_\_

HOSPITAL \_\_\_\_\_

ATTENTION \_\_\_\_\_

CITY \_\_\_\_\_ Zone \_\_\_\_\_ STATE \_\_\_\_\_

H458

# Disposable Syringe Medication

## A Review of Advantages and Three Outstanding Examples

**A**N INCREASED TREND toward the acceptance and use of disposable syringe medication is evident in hospitals throughout the country. Many "standard" hospital parenteral products are now being offered in this relatively new dosage form by pharmaceutical firms. Consideration of some of the advantages of disposable items helps to account for this increasing demand.

### Assured Sterility

Since some manufacturers (e.g., Organon) supply a completely sterile disposable needle and syringe with the cartridge of medication, the danger of inducing infectious hepatitis or pyrogenic responses in patients is greatly reduced. In addition, the disposable units may also reduce the incidence of serum sickness and anaphylactoid reactions in hospital personnel. Protection is afforded the person preparing the injection, since no withdrawal of a needle from a vial is necessary. Thus there is little risk of puncturing or scarifying his skin.

### Expedites Medication and Charges

The time consumed by nurses and pharmacists in preparing injections is greatly reduced through use of disposable units, since these are always ready for immediate use. This allows nurses to spend more time in actual patient care. In addition, since the disposable unit is completely used up after each injection, the patient need not be charged for a full multiple-dose vial nor need the hospital pharmacy assume the loss for a partially used vial.

### No Waste

Precision dosages are assured in the disposable units. This decreases waste of medicament, facilitates inventory control, and increases the efficiency of the hospital pharmacy. In addition, central supply operating costs are reduced through fewer syringe breakages, and reduced need for washing, assembling, sterilizing and storing hypodermic equipment.

### Better Patient Psychology

Patient comfort and well-being are increased when the patient becomes aware that the needles are used only once and discarded. In addition, each needle is new, burr-free, and sharp, minimizing the pain on injection.

### Economy

Some manufacturers (e.g., Organon) price their disposable units so that the hospital pays only the cost of the medication itself plus the manufacturer's cost for the disposable needle and syringe. This helps make medication administered in disposable units economical, and, when the other advantages of disposable units are considered, a real advance over the use of standard hypodermic equipment with multiple-dose vials.

In line with the trend toward increased hospital usage of disposable syringe medication, Organon Inc. of Orange, New Jersey, a pharmaceutical firm with more than two decades' experience in the manufacture and marketing of quality parenteral products, recently introduced three of its hospital products in disposable unit form. These products are Cortrophin®-Zinc, Liquaemin® Sodium, and Adrestat® (F). Each of these products is available in a package containing a 1-cc cartridge of medication and a sterile B-D® Disposable Syringe. The packaging of this Organon disposable unit is unique in that the needle and syringe are packaged in a sterile plastic bag, assuring sterility to the moment of use.

*Cortrophin-Zinc* is Organon's exclusive aqueous suspension of long-acting corticotropin (ACTH) with zinc hydroxide. It provides therapeutic ACTH activity for far longer periods than can be obtained with ACTH in any other vehicle. In disposable units, Cortrophin-Zinc 1-cc cartridges are available in two strengths: 40 U.S.P. units of ACTH per cc, which provides ACTH activity for 72 or more hours, and 20 U.S.P. units of ACTH per cc, which provides ACTH activity for 36 or more hours. With its wide range of indications (over 100), Cortrophin-Zinc in disposable unit form is a valuable hospital item.

*Liquaemin Sodium* (Heparin Sodium) is America's first and finest heparin. Its usefulness in the prophylaxis and treatment of thromboembolic and atherosclerotic disease is well established. In disposable units, Liquaemin Sodium 1-cc cartridges contain 20,000 U.S.P. units of heparin sodium (approx. 200 mg.) in aqueous solution. This strength and form of Liquaemin provides prolonged anticoagulant activity equal to that of the same concentration of heparin in gelatin, and without the inconveniences of a gelatin menstruum.

*Adrestat (F)* is Organon's systemic hemostat (Carbazochrome Salicylate) indicated in the prevention and control of bleeding and oozing. In disposable units, Adrestat (F) 1-cc ampuls contain 5 mg. of adrenochrome semicarbazone (as 130 mg. carbazochrome salicylate\*\*). This form of Adrestat (F) is particularly useful in emergency clinics and for pre- and post-operative use.

*Further information on these three products as well as extra copies of this article for use in presenting the advantages of disposable syringe medication to Formulary or Therapeutics Committees may be obtained by writing to Hospital Sales Department, Organon Inc., Orange, N. J.*

**References:** Bogash, R. C. and R. Pisanelli, *Hosp. Mgt.*, 80:82 (Nov.-Dec.) 1955. Hunter, J. A., et al., *Hosp. Mgt.*, (Mar., Apr., May) 1956. Skolaut, M. W., and W. H. Briner, *Bull. Amer. Soc. Hosp. Pharm.*, 14:675 (Nov.-Dec.) 1957. Tinker, R. B., *Bull. Amer. Soc. Hosp. Pharm.*, 13:319 (Jul.-Aug.) 1956. (These references indicate sources of factual material and do not imply use of the preparations described herein.)

\*T.M. Reg. Becton, Dickinson & Co.

\*\*U.S. Pat. Nos. 2,581,850; 2,506,294

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# STERILE PACKAGED

BARDEX® FOLEY CATHETERS

**READY FOR INSTANT USE  
WITHOUT PROCESSING OR AUTOCLAVING**

**Saves time**, labor and nuisance—no delays for processing and autoclaving, no problem of trying to anticipate and process in advance the sizes that may be needed. No waits at time of emergency!

**Saves money**—eliminates the costly steps of processing and sterilizing—gives a *known fixed* catheter cost.

**Convenient**—simplifies the catheter inventory control problem for Central Supply. Requisitions can be filled *at once*—the right size catheter, easy to open, sterile, ready for instant use.

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C. R. BARD, INC. • SUMMIT, N. J.



The  
**LOOKING GLASS  
FINISH**

**TELL TALE**



WITH **"VERI-FIRE"**  
**PERFORMANCE TRACER** PATENT  
PENDING

**A STARTLING NEW FLOOR  
FINISH THAT IS BOTH  
VISIBLE *and* INVISIBLE**

**... STYLE'S LOOKING GLASS  
LETS YOU SEE APPLICATION,  
WEAR *and* REMOVAL**



**THRU VESTAL RESEARCH . . . ANOTHER NEW PRODUCT FOR BETTER MAINTENANCE**

## END DECEPTION

Your eyes can be easily deceived. They'll see a high gloss on floor finishes when the gloss really is on the floor itself; they'll tell you one finish lasts as long as another when there's a big difference in the wearing qualities of the two; they'll mislead you into believing your floors are well protected when the floors aren't protected at all.

Why? Because the thin film left by floor finishes can't be seen. It's transparent. That's why the gloss you see may be a shine on bare tiles, not a shine on protective finish.

## DON'T GUESS...KNOW

Now for the first time new tell-tale STYLE ends the guess work—gives you the true picture of the finish on your floors.

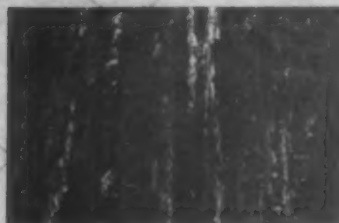
New STYLE with the "Performance Veri-fire" is invisible under ordinary light, but when you cast, safe easily-available black light (Long Wave Ultraviolet Illumination) on the new STYLE finish, it immediately glows—you see the finish. See the comparative photographs below of the 4 floor tile panels, each under ordinary light and under "black light."

## WHAT YOU SEE

### UNDER REGULAR LIGHT



Leveling appears to be good.



Application looks uniform.

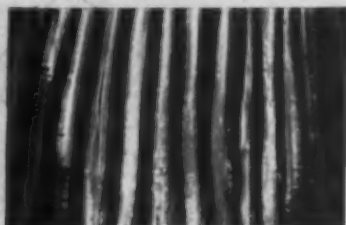


Finish shows no apparent wear.



You can only guess if stripping has been complete.

### UNDER BLACK LIGHT



Leveling is actually poor.



Proves application is uniform.



Finish shows hard wear.



If fluorescence is gone you know stripping has been complete.

## What is STYLE?

STYLE is a completely synthetic floor finish consisting of long-wearing copolymer plastic resins, dispersed in water emulsion form. Producing a longer-lasting, protective finish on floors, it is designed to replace self-polishing floor waxes. It has high water resistance — (permits damp mopping)—yet it is easily removed by ordinary wax stripping methods. A coating of STYLE is dirt-resistant and scuff-resistant—retains its initial brilliance longer than any wax product. This means lower labor costs while maintaining excellent appearance.

### How does STYLE'S "Veri-Fire" Work?

Simple, very simple . . . a portable black light is held above the STYLE finished floor. Immediately, like a touch of magic, the looking glass fluorescence in the STYLE finish takes fire and TELLS:

1. If application is complete and uniform.
2. If good leveling has been obtained.
3. If the finish requires re-application.
4. If there's too much build-up.
5. If stripping has been complete.

Right before your eyes the *true* condition of the floor finish has been positively determined. You can then take the necessary steps as indicated by the black light analysis.

### What does this Tracer mean to you?

It means that with the use of STYLE on your floors, you can keep tight control over your maintenance program . . . Eliminate wasted man hours . . . Eliminate excessive use of materials . . . This gives proof positive at all times that you have a quality product. This guarantees dollar savings to you.

### Only STYLE Dares to Tell!

Only STYLE can risk the "Veri-Fire" Performance Tracer!

Only STYLE lets you see for yourself!

### Look in the Looking Glass!

Without obligation we will send our representative and his "black light" to demonstrate right on your own floor that STYLE is a revolutionary product with revolutionary performance control . . . SEEING IS BELIEVING. Just write us on your letterhead. But do it TODAY.

**VESTAL**

INCORPORATED

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WEST COAST PLANT • MODESTO, CALIF.  
Vestal Products are Warehoused in all Principal Cities



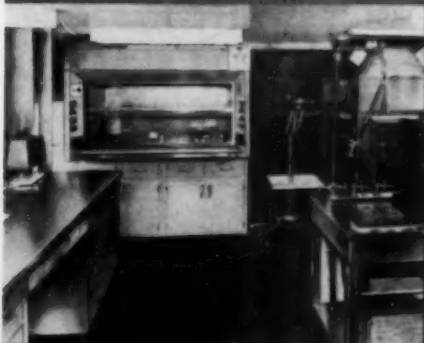
## CHEMISTRY

Typical laboratory installations designed to meet the varying conditions created by modern scientific research. Our customers have availed themselves of our planning and engineering experience combining this know-how with our ability to offer combinations of materials, we have been able to effect utility, economy and complete customer satisfaction.



## AUTOPSY

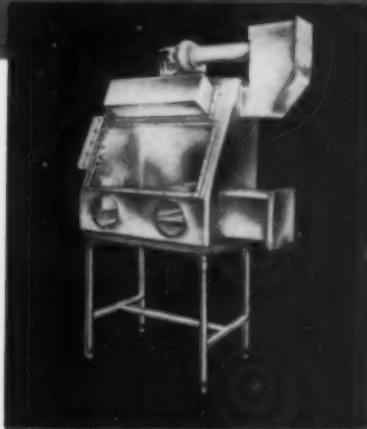
## RADIO-ISOTOPE



**RADIO ISOTOPE FUME HOOD:** Designed for controlled air flow. Available with Stainless Steel, Transite or Chemstone interior. Exclusive Multi-Channel sash, counter balanced for smooth sliding finger tip control. HOSPILAB will engineer this fume hood to meet your exacting requirements. All services connected by remote controlled handles, individually labeled and easily accessible.



**LOW INTENSITY DRY BOX:** This unit is designed for hazardous materials where contamination is dangerous to personnel. Dry Box is used for handling Radio-Isotopes, Radioactive Materials, Bacteria Viruses, and other hazardous materials. The basic design of this unit is currently accepted by all Atomic Energy Commission Laboratories. HOSPILAB will vary the design and construction of this unit to meet your specific requirements. Unit is constructed entirely of Stainless Steel with generous coved corners for easy cleaning and decontamination.



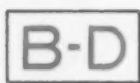
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# Hospilab EQUIPMENT CORPORATION

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THE  
BARREL  
IS  
GLASS  
HYPAK<sup>®</sup>  
STERILE  
DISPOSABLE  
SYRINGE-NEEDLE  
COMBINATION

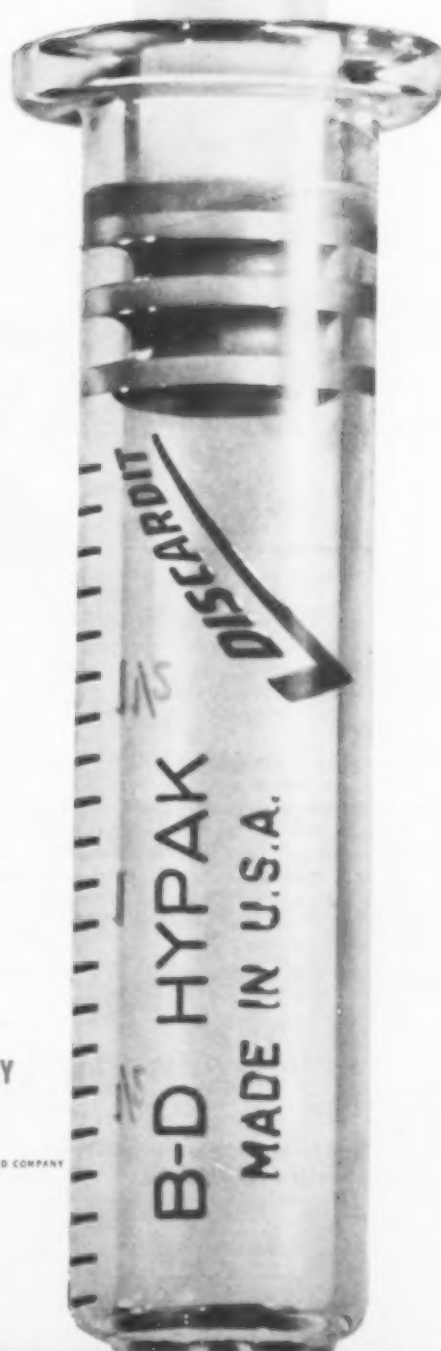
- all-glass barrel...the material proved safe by time and use
- no solvent action...even after extensive, prolonged contact with parenteral fluid
- sterile, pyrogen-free, nontoxic...  
B-D Controlled from top to tip
- new, sharper needle point for one-time use...greater patient comfort



BECTON, DICKINSON AND COMPANY  
RUTHERFORD, NEW JERSEY

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United Hospitals Appeal is a proved method of capital fund-raising for as few as two hospitals to groups of ten or more in a community. Past appeals have raised sums ranging from \$350,000 to \$17,500,000.

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### **WHAT IT COSTS**

The cost of conducting a United Hospitals Appeal is remarkably low in relation to the amount which can be raised. Of course, each appeal is different—varying with the community's needs and the potential area of donation. But in general, Bureau experience shows it costs from one percent to five percent of the total money raised. This includes all costs; the Bureau's fee, clerical expense, printing, postage, meetings and all other items necessary to the success of a fund-raising campaign. The Bureau's fee is always a flat amount depending on the length of time, and size of staff required. The total cost of a campaign is shared proportionately by the participating hospitals.

### **WHAT THE BUREAU DOES**

American City Bureau takes the entire fund-raising problem off your shoulders. An experienced Bureau staff moves in to evaluate the community's problem. They contact all hospitals concerned, establish goals, organize volunteers, supervise clerical work, conduct meetings, direct publicity, account for and distribute all monies received.

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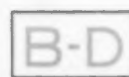
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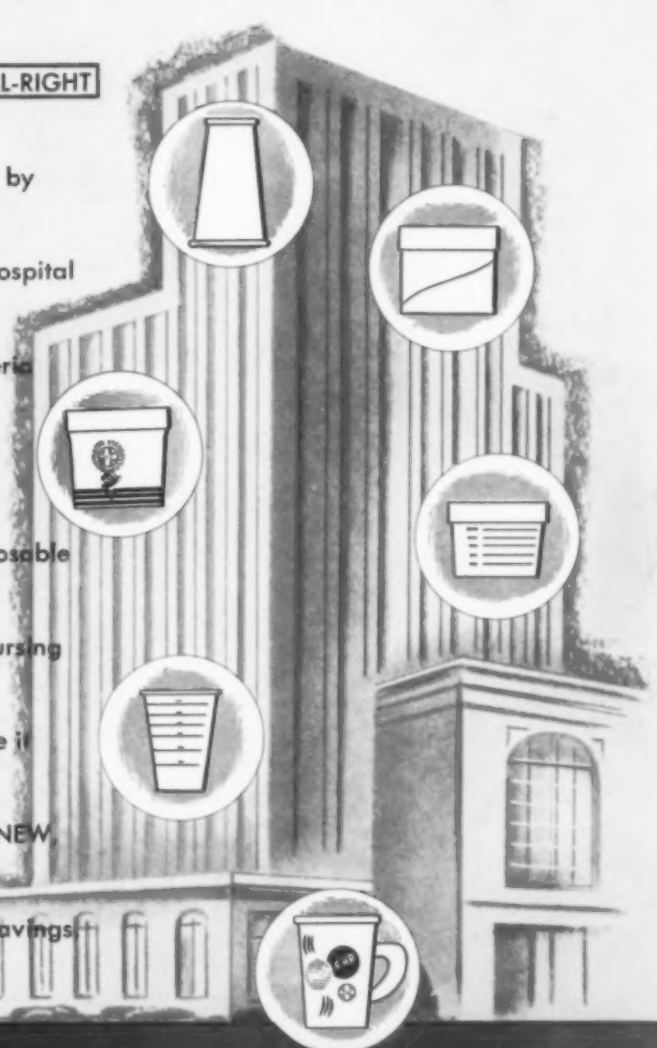
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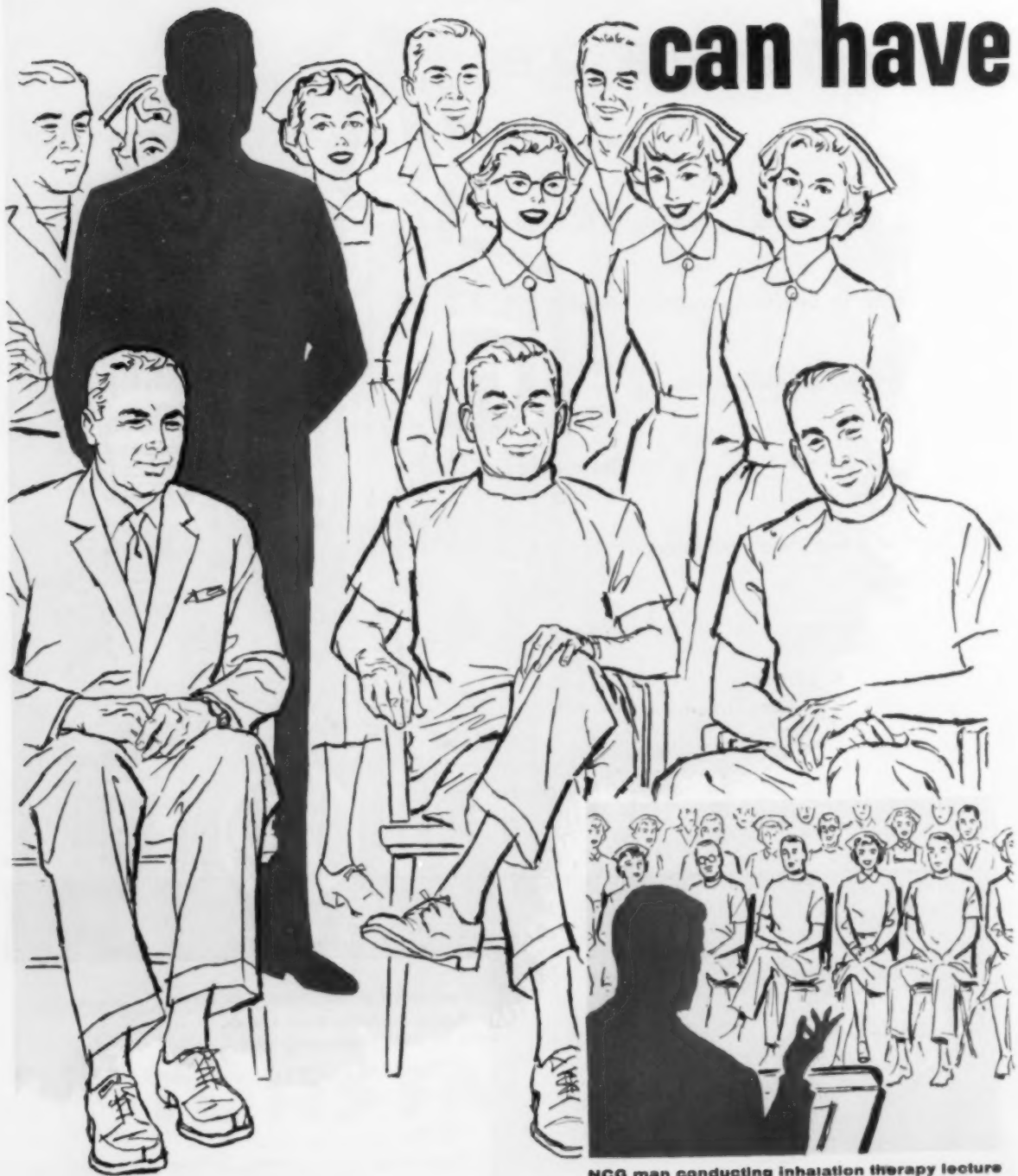
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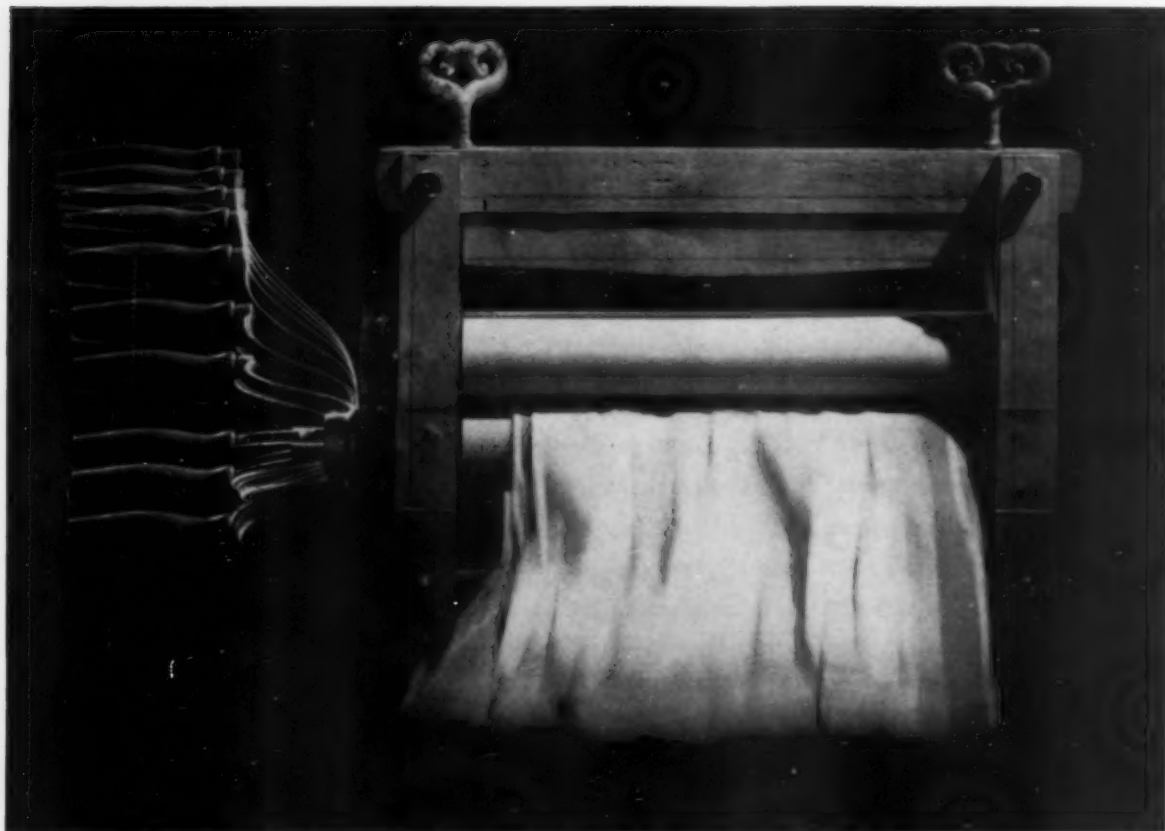


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## SMALL HOSPITAL QUESTIONS

### Raw Food Costs

**Question:** We have had complaints about food and food service and, as part of a program aimed at remedying this situation, had a spot study of costs made by our accountants. The study showed we were spending 39 cents per meal for "raw food costs" and 65 cents per meal total cost. Are these figures in line with hospital food costs elsewhere?—G.A.W., La.

**ANSWER:** Food costs vary considerably from one part of the country to another, and among different types and sizes of community, so the comparison should be made with other hospitals in your own locality or area. The figures given are near the low end of the range of food cost experience reported by most hospitals and would indicate you are in a low-cost area.

### Effects of Automation

**Question:** What effect will automation have in the future planning of hospital food service departments?—T.B., Tex.

**ANSWER:** Increased automation will have the following results:

1. The initial investment for equipment will be more expensive. The new equipment will require better training of employees both to operate it and to avoid costly repairs brought about by negligence or improper use. Thus, although there may well be fewer employees required to perform in a specific area, their rates of pay will be proportionately higher.

2. The increased trend toward the use of preportioned, processed and ready-to-use foods will tend to require less kitchen space and equipment. Automation plays a part here. Manufacturers, by using such equipment, will do a better job at a correspondingly lower price, thus offering added incentive to the institution to purchase these products.

3. As vending machines become more versatile and efficient and offer a wider variety of foods, this type of service will increasingly become a part of the food service operation for personnel and visitors. Particularly will this be true during off hours and on week ends; possibly, machine vended items will be used to supplement regular meal service.

4. As to dining room space, automation as such is not a factor. The

only possibility lies in speedier service because of automatic equipment, thereby increasing turnover and, thus, requiring fewer seats to provide service for the same number of people.

Constantly rising labor costs have forced increasing numbers of food service operators to use automatic equipment of all kinds. Too, many types of automatic equipment take the guesswork out of food preparation in addition to reducing labor costs.

### Employment Practice

**Question:** In our small hospital we do not have a personnel director. New employees are interviewed by department heads and in most cases by the administrator. We do have an application form to be filled out by persons being interviewed, including a place to list references, but sometimes when we are shorthanded we go ahead without checking the references. In most cases, this has worked out very well, but we have a feeling this is not proper procedure and department heads should be instructed not to employ anyone without a direct reference. Is this correct?—D.N.H., N.Y.

**ANSWER:** Yes. Even the most exhaustive interview will leave many questions unanswered about the applicant's work record, character and desirability as an employee. Furthermore, references carried by the applicant and furnished by him at an initial interview, such as letters addressed "To Whom It May Concern," are generally regarded as valueless by personnel people. Where a real emergency exists and the applicant seems to be suitable, a check can always be made by telephone with the previous

employer to ascertain if the applicant is telling the truth about his or her experience and to make certain there are no obvious reasons he or she should not be employed. Often the direct reference is the only way to detect the person who is an alcoholic, a troublemaker, chronic complainer, or petty thief, and who would not make a desirable employee under any circumstances.

Some employers follow the practice of checking references first by telephone, then, after employment, asking for written recommendations from previous employers, for the employee's personnel file. Especially in an institution performing a public service, it is good practice to have written references for every employee indicating the hospital has not been negligent in determining qualifications and suitability for employment.

The written application for employment is also an important part of the personnel file, and there should be such a signed application for every employee. If you are doubtful about the form you are using, you can easily check it with application forms used by businesses and industry in your community, to make certain it is complete as to the information requested and obtained.

### Painting Schedules

**Question:** What is the best way to maintain painted walls? We are wondering whether we should (1) repaint—one or two coats—every three years, (2) alternate washing and repainting every third year, (3) or wash every third year for several successive times and then paint as the needs arise in the room.—R.M., Ind.

**ANSWER:** There is no one answer to this question. Much depends on the condition of the surface to be maintained such as the character and intensity of the dirt and the condition, color and type of paint that is to be covered.

In general, it is well to apply as little paint as is necessary to give a satisfactory job, thus avoiding the buildup of a heavy coating of paint. Where conditions permit, it is best to do a fair wash job and follow with one coat of paint. Unless environmental conditions are extremely bad, painting every three years cannot be justified.—B. M. WILSON, Rochester, N.Y.

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R.N., Frazier-Ellis Hospital, Dothan,  
Ala.; A. A. Aifa, San Antonio  
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Outstanding features include: a central service

core in the main wing; cantilevered support for the floors; exterior walls of aluminum-trimmed plate glass with ceramic coloring fused onto the glass spandrels; complete climate control plus a 600-speaker sound system; a unique new lighting system designed by the architect featuring a combination of fluorescent tubing and translucent plastic panels that virtually eliminates glare. The plumbing also reflects this detailed planning for efficiency—the flush valves, of course, are SLOAN.

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## wire from **Washington**

### OUTLOOK FOR HEALTH BILLS

The Easter recess, which traditionally marks the approximate halfway mark in a session of Congress, shows no hospital-medical bills of any consequence passed so far, and committee action on very few.

But the prospects for the second half are a different thing. Congress by now is beginning to turn an eager eye on several bills that would have an impact on the health field.

Most certain of enactment is legislation of some type to use federal grants as insurance that the best young scientific minds will be developed at least through four years of college. This would affect medicine in several ways. With more and better science students getting a start in college, the medical schools would have a better group to choose from.

This legislation has been under review and discussion in Senate and House committees most of the time since the start of the session in January. If only one health-welfare-education bill is to pass this year, the aid to education measure would be it.

Although details have not been worked out—both parties will want to take credit for the final product—the bill to be enacted is certain to affect medical education in two ways:

1. Many premedical students will have their way paid by Uncle Sam, and under certain circumstances it is likely that the assistance for some will extend through the first or second year of medical school.

2. Fellowships will be offered to a limited number of medical graduates, if they agree to concentrate on research in preparation for a career in medical research or in medical teaching.

There is also mounting pressure on Congress to enact a massive public works construction program—hospitals included—as an antirecession measure. In their annual meeting in Washington, legislative leaders of the A.F.L.-C.I.O., 1000 strong, moved up to Capitol Hill to button-hole their senators and representatives.

High on their list of legislative objectives are these:

1. Extend the Hill-Burton hospital construction program for another 10 years, making the plan virtually permanent and assuring long-range planning and fund raising at the community level.

2. Appropriate all of the \$210 million that Congress has authorized for annual Hill-Burton spending.

### HILL-BURTON FUNDS RISE

The White House campaign to hold down spending under Hill-Burton came to a shuddering collapse.

By the time the President bowed to the inevitable and asked that the Budget Bureau recommendation of \$75 million be raised to \$121 million, it was pretty clear that Congress was going to pull the figure way up, White House or no White House.

Before the White House reversed itself, even Speaker Clarence Cannon (D-Mo.) of the appropriations commit-

tee, a hard-boiled champion of economy, had been won over to more spending as a depression antidote.

Dr. John Cronin, assistant surgeon general of the Public Health Service, age 52, died of a heart attack March 26. Prior to his promotion to assistant surgeon general in November 1956, Dr. Cronin had been chief of the Hospital Facilities Division for seven years.

tee, a hard-boiled champion of economy, had been won over to more spending as a depression antidote.

As long ago as February, Chairman John Fogarty of the health appropriations subcommittee had in effect notified Secretary Folsom not to gear down to the \$75 million figure. Rep. Fogarty's remarks, made during a closed session, were released shortly before the Administration officially admitted the \$75 million was too low. Addressing Mr. Folsom, Rep. Fogarty said:

"If other members of Congress are getting the telegrams I have been receiving regarding this cutback in hospital construction, you people are going to have some more money, I would guess, to build hospitals with. It seems every state in the union is writing in now that they have plans that it would take two years from now to complete even if we appropriated two or three times what you requested.

"I think that was a pretty poor decision of the Bureau of the Budget to make this cut. Some of these states have applications that not only won't be taken care of next year but won't be three years from now under the level of appropriations proposed in this budget.

"There are many communities that are going to be hurt by this decision of the Budget Bureau unless Congress does something about it."

The chairman then asked the Secretary: "Do you agree with that?"

The Secretary admitted that his department had asked the Budget Bureau for the "full amount" for next year, but didn't say whether he meant the \$121.2 million allowed this year or the \$210 million that could be voted under the law. The question was not further pursued.

### SPOTLIGHT ON THE AGED

Problems of the aged—their medical care particularly—continue in the spotlight in Washington.

Within one two-week period, two national meetings here were devoted exclusively to attempting to decide (a) what if anything the government should do to help the aged, and (b) what could be done for them outside the government.

The first was a four-day session called by Public Health Service to talk over all the problems of nursing homes and homes for the aged and to reach recommendations. Attending were about 150 delegates, including a small minority from the proprietary homes which handle more than 90 per cent of the patients.

This group skirted around the Forand bill controversy. Instead of supporting or opposing this plan (for hospital-

ization and nursing home care under social security for those over 65), the conference merely said the federal government had to do something. Its resolution read:

"There is need for federal legislation further to encourage financing for the construction and renovation of nursing homes and homes for the aged, including a set of recommended construction standards for use by the financing agencies when such construction or renovation meets clearly demonstrated local needs. The need for such legis-

lation is so urgent as to require prompt consideration by appropriate executive and legislative sections of the federal government."

Other recommendations: A private physician for all nursing home patients, and a medical adviser for home operators; written orders for drugs and treatments and adequate medical records; state licensing authorities should evaluate the moral, mental, financial and educational qualifications of the operator, as well as the facility itself.

## Houston Hospital to Construct Emergency Rooming-In Unit to Combat Staph. Outbreak

HOUSTON, TEX.—Construction of a frame structure adjoining Jefferson Davis Hospital here to house an emergency rooming-in nursery was scheduled to begin late in March. It was one move in the 600 bed city-county institution's campaign against an outbreak of staphylococcus infection in its nurseries which has resulted in the deaths of 16 infants since January 1, according to Alfred S. Reaves, the administrator. The building was expected to be completed in "a couple of weeks," Mr. Reaves said in an interview on March 24.

Other measures that have been taken since the infection started, it was reported, include abandonment of the newborn nursery as fast as it was possible to get the infants out, and the setting up of a new nursery for newborns and a special isolation unit for infected infants and those suspected of harboring infection. The old nursery, which had been cleaned and repainted shortly before the outbreak of the infection, will be remodeled to provide for more partitions separating the bassinets, Mr. Reaves stated. Overcrowding in the nursery is considered to be the primary cause of the epidemic, he added.

Until the new rooming-in unit was completed, all new patients were to be kept off the fifth floor of the hospital, which houses the obstetrical and maternity division. The mothers would be delivered in the regular delivery room, Mr. Reaves explained, and the infants would then be removed to another section of the institution.

In an effort to find the carriers of the staphylococcus organism, identified as Type 52/42B/81, health department technicians have made nose and throat cultures on hospital staff members who come in contact with the mothers and infants. Preliminary tests, according to health department officials, indicate that "over half" of the 123 employees of the hospital's pediatrics department are harboring the epidemic organism.

"We have found quite a few carriers," Mr. Reaves said, "and have removed all of those who have anything

to do with the infants from duty in the area."

Asked if any of the mothers had been affected, Mr. Reaves said he believed that "a few mothers had returned to the clinics for treatment of breast abscesses."

Not only city but state and federal public health officials have been working on the outbreak in Houston. An epidemic that has caused nine deaths also has been reported in Dallas.

In a newspaper interview, Dr. Alexander Langmuir, chief of the epidemiological branch of the Communicable Disease Center, Public Health Service, Atlanta, Ga., pointed out that "this virulent or epidemic strain is present in all parts of the country." He said the Communicable Disease

Center has investigated about a dozen outbreaks similar to the one in Texas and is offering doctors and nurses to give advice and guidance through state health departments to any hospital or county that has a problem.

Dr. Langmuir called for "a return to the first principles of rigid aseptic technics in hospitals."

He continued: "The staphylococcus likely will always be with us. It is in the air, the dust, everywhere. But the one or more particularly virulent strains which have developed in recent years is what is really aggravating the problem."

The epidemic strain of the infection is now causing four main types of problems, Dr. Langmuir said. He listed these as impetigo in babies, breast abscesses in nursing mothers, surgical wound infection, and serious infections in chronic bedridden patients.

## Strikers Picket Swedish Hospital in Seattle; Union Seeks Recognition as Bargaining Agent

SEATTLE.—A strike by the members of Local 301, Hospital Workers' Union, a subsidiary of the Building Service Workers' Union, tied up some services at the Swedish Hospital here beginning at 5:30 a.m. March 20.

The hospital continued to function, but with difficulty. By the week-end, it appeared the strike might continue indefinitely.

The pickets began marching before entrances of the 375 bed hospital, Seattle's largest nonprofit institution, in an effort by the union to enforce recognition of the union as a bargaining agent for 300 housekeeping, non-professional nursing, and nonprofessional dietary employees.

The hospital had 365 patients when the strike began, and its census continued at near-capacity levels in the early days of the strike. No direct services to patients were interrupted, and supervisory personnel and non-union employees maintained almost normal conditions.

Most serious problem for the hospital was shutting off of steam supplies to the laundry. Steam to the kitchen (for steam tables, dishwashers and sterilizers) was shut off for one eight-

minute period but was reopened by an administrative worker. The hospital placed an armed guard on steam valves leading to the kitchen thereafter.

The steam and refrigeration plants are operated by members of the Operating Engineers' Union, who were given passes to cross picket lines. Eugene R. Hooper, president of the Hospital Workers' Local, said the passes would be revoked unless steam to the laundry remained shut off. This would have the result of shutting down all steam for heat and sterilization and all refrigeration.

Hooper also threatened, in statements to newspapers, to withdraw the engineers' passes unless steam to the kitchen were shut off.

Some deliveries of supplies were curtailed as members of the Teamsters' Union refused to cross picket lines. Some fresh bread, milk and perishables were delivered only to the sidewalk outside the picket lines, and then taken in by supervisory personnel.

Pickets permitted deliveries of medical supplies and oxygen. A truck containing medical supplies was backed

(Continued on Page 130)



## LOOKING AROUND

### Quick, Whiskey!

WE'VE been puzzled ever since about a piece we saw recently in a hospital association bulletin. "Study Shows Few Alcoholics Leave Unpaid Hospital Bills," this said, reporting that one hospital found alcoholic patients a good financial risk, with 98.9 per cent of their bills either covered by insurance or paid by the patients themselves.

Where will this lead to? The bulletin says the study was undertaken to "help determine the rôle the general hospital should play in the treatment of alcoholism." With 98.9 per cent of bills paid, it may prove even more about the alcoholic's rôle in the treatment of the general hospital.

### Education Problems

REVIEWING the publicity released by its sponsors in anticipation of Medical Education Week, an occasion which will be observed later this month by the deans and faculties of the medical schools and probably very few others, since the public is generally surfeited and bored by the unending succession of Days and Weeks celebrating everything from bread and gravy to good posture, the reader cannot fail to be impressed with what our medical schools have accomplished in recent years, in the face of almost overwhelming odds. Lacking money, and teachers, and patients—everything, in fact, but students, and these are by no means as plentiful as is commonly supposed—the schools have nevertheless managed to increase their output of physicians by 30 per cent since 1940, gaining slightly on the general population, which increased by an estimated 29 per cent over the same period.

The number of medical schools has been increased from 77 in 1940 to 83 approved schools today, plus two new four-year schools, at the University of Florida and Seton Hall, which will not be eligible for approval until their first classes graduate two years from now. Another school is scheduled to open next year at the University of Kentucky. In spite of this added capacity, it is expected that the production of physicians is going to fall behind the population increase some time in the late 1960's, when an estimated 7300 new medical graduates each year will be unable to hold the line as the U.S. population soars beyond 200,000,000.

Some physicians and economists argue that we won't need as many doctors in proportion to the population in the future as we have needed in the past, because the individual physician's effectiveness, and the number of patients he can attend, have been multiplied by advancing medical technology—an advantage others think is offset by the growing number of aged people requiring more and more medical care, and by expanding needs for medical service in public health, industry and the new medical specialties that are appearing all the time. Either way, it is generally agreed that the need for nurses, pharmacists, and medical technicians of all kinds will grow even more rapidly than the need for physicians, imposing still greater burdens on the medical schools, which must also manage to provide post-graduate programs for physicians in practice who have to keep up with the dizzy pace of medical science.

Who's to pay? Generous as industry and doctors have been in their support of the medical schools, the few millions that come along each

year from the National Fund for Medical Education and the American Medical Education Foundation are only a fraction of the amount needed if the schools are to expand as they should, keep tuition charges in line with what most families can afford and thus prevent the drift toward economic selectivity in medical careers, and pay faculties enough so the whole medical teaching load will not be divided among a few dedicated souls who aren't interested in money, a few others with rich wives, and a lot of busy clinicians who toss off lectures and rounds as they dash back and forth from office to hospital looking after their private patients.

As if these difficulties were not formidable enough, medical education is also confronted with the need for finding answers to two more problems that may prove, in the end, to be the most baffling of all—the dwindling number of ward patients available for clinical teaching and the ever-growing body of scientific knowledge that must be crowded into the curriculum. Unlike all the other problems, which are susceptible of solution in terms of money, these can only be solved by thinking, which is much harder, even for educators.

Fortunately, the thinkers in medical education are hard at work thinking about both problems. At the last Congress on Medical Education and Licensure it was agreed on all sides that private patients would have to be used more and more in clinical teaching, to take the place of the charity patients who aren't there any more. The practice of using private patients without telling them they are being used was condemned by everybody, including some teachers who admitted privately this is exactly what they have been

doing. "We know that with the proper approach, private patients will cooperate willingly," said one educator—unquestionably a man who has never had to pay \$28 a day to lie in a hospital bed while the clerk, intern, junior resident, and senior resident came on successive visits to palpate the spleen.

While the private patient may prove to be harder wax to mold than some educators imagine, it is heartening to find the medical schools facing up to basic changes in medical and hospital economics and not telling one another cheerfully—as we are so likely to do in so many enterprises—that the change is only temporary and the wards will soon be filled again (a proposition that has a certain plausibility, it must be acknowledged, just at this time). It is encouraging, too, that the medical schools are also aware of the need to keep the curriculum from expanding further without cutting the physician off from the rest of society by limiting his education to scientific subjects. Experiments integrating the premedical and medical years are already under way in at least one school, and similar experiments are under consideration elsewhere. Eventually, these experiments if successful may actually shorten the time it takes to educate a physician and at the same time produce one who is still able to communicate with nonphysicians—a phenomenon that would be welcomed by many who remember the days when a doctor who couldn't quote Ovid and play the violin was regarded as something of a fraud, much as though he had forgotten the location of the common bile duct. At the recent Congress on Medical Education, a workshop session reported its members agreed that the concept that every graduate physician should know every field of medicine would have to be abandoned. "We must settle for a certain amount of ignorance," the workshop said calmly. "The thing that has to be determined now is how much ignorance—and in what fields?"

This is the kind of thinking that gets problems solved, and we have a suggestion for the sponsors of Medical Education Week: Instead of restricting the week's publicity to the glories of medicine and the need for money, let the public know about problems like the necessity for using private patients in teaching and settling for a little ignorance on the part of doctors. In medical education as in politics, there is much to be said for Jefferson's

dictum that given right information, the public makes right judgments.

### Rubber Stamp

IT WAS just a year ago, on April 8, 1957, that the General Assembly of the State of Iowa approved House File 21—the "Pathology and Radiology Services in Hospitals Act." Shortly afterward, the Iowa Hospital Association withdrew its appeal to the Iowa Supreme Court of the district court decision in the lawsuit against the state pathologists' and medical societies, thus apparently terminating, if not solving, the long-standing controversy between Iowa's hospitals and doctors.

According to where one sits in church the light may fall on the bride or on the tipsy usher, and the wedding will seem either a maiden's dream or a drunken shambles as a result. In much the same way, events in Iowa during the last year may be variously interpreted as a dream or a shambles according to where one sits. In the medical view, the troublesome business of hospitals practicing medicine has been settled by the law, and "a smooth, gradual transfer of pathology and radiology services from Blue Cross to Blue Shield" is being effected. Hospital people insist that the corporate practice of medicine issue was shadowy to begin with and hasn't been substantively changed, and, from the hospital side, the transfer of benefits from Blue Cross to Blue Shield is a lot more gradual than it is smooth.

Rough spots appeared in the transfer before the ink was dry on the Act, when it developed that the administrative cost of shifting benefits from Blue Cross to Blue Shield would mount up to an estimated \$33,000, plus additional operating costs, in one plan alone. A Blue Shield proposal that these costs should be paid by a 10 per cent withholding tax to be deducted from payments to specialists for their services was rejected by the specialists, who thought the costs should be carried by the hospitals. "Each hospital became a battleground for new negotiations between the hospital and the specialists or general practitioners supervising these departments," one hospital administrator reported. "A number of hospitals had difficulty persuading any doctors to supervise the departments."

The payment problem was not settled until a couple of months ago, when Blue Shield finally agreed to bill

the specialists directly for the costs, leaving hospitals and subscribers out of it. Some hospitals still haven't persuaded physicians to take on the supervision of laboratories and x-ray departments—a circumstance that may owe something to the doctor's increased sensitivity to malpractice liability in our time.

The Act also provided that "the hospital bill shall properly include the charges for pathology and radiology services as long as the name of the doctor is stated and it fairly appears that the charge is for medical services." In common practice at Iowa hospitals today, it fairly appears that the charge is for medical services because the hospital bill includes a rubber stamp that says so and the doctors' names have been added, usually in eight-point type, at the foot of the bill. The essential relationship of hospitals and doctors is covered in Section 8 of the Act, providing that "the contract . . . may contain any provision for compensation of each upon which they mutually agree," and the essential relationship is thus plainly unchanged, since it always takes two to make a contract.

At some pain to themselves and others, Iowa physicians are getting pathology and radiology services out of Blue Cross and into Blue Shield—a maneuver that was obviously important to them, since it was a medical society request that this be done that touched off the controversy in the first place. In a few hospitals, unquestionably, service to patients will improve as competent specialists take over active supervision of pathology and radiology departments. In hospitals where competent professional supervision existed before the new law was passed no change has taken place. In other hospitals where the appointment of any physicians who would accept the assignment has been made to meet the letter of the law, it is doubtful that the service has been affected much one way or the other.

In addition, of course, the physicians have gained a rubber stamp and a line of eight-point type, and these may be important or not according to whether the light falls on the bride or the usher. The rubber stamp says radiology and pathology are medical services, as indeed they are, but its appearance on hospital bills suggests that they are also hospital services, and there is nothing in the law that says they can't be both.

# You Know What You Mean—But Who Else Does?

Breakdown in communication is a common failure in  
administration and it comes about all too often  
because the person who is transmitting instructions  
or information doesn't say precisely what he means

S. G. HILL

ONE of the most important aspects of any administrative enterprise is communication, which includes all that is involved in the transmission of information from person to person and from place to place.

Without question, major battles have been lost because what was known to General A at place X could not be transmitted to General B at place Y. Most discussions upon communications concern the technical means of transmitting information and, with advances in science, it is now possible to transmit messages in almost any circumstances. This article deals not with the means of communication but the general principles upon which communications should be based.

In other words, we are not concerned here with *how* information should be conveyed, but with *what* the content of that information should be. Although less attention is generally paid to the substance of communications than to the means, there is no doubt that a study of the principles involved will be of value.

To revert to our previous example, battles have probably been lost not only by failure in the means of com-

munication, but also because of defect in the substance. General A might have established contact with General B but if the vital information did not pass between them with the proper speed and accuracy, the effect could be as bad as (or perhaps even worse than) a complete absence of the means of communication.

It has already been stated that communications are involved in almost any administrative enterprise, and the hospitals are no exception to this general rule. It is suggested that most of what is said here would be true of most organizations, but here and there reference will be made to matters which are peculiar to hospitals. Perhaps a rough analysis of the various categories of communication will assist in eliciting the relevant principles.

The most obvious primary division of communications is between written and verbal communications. Each type of communication has its own merits and demerits. Written communications are valuable mainly in that they constitute a permanent record, and so it is obvious that any matters to which constant reference

needs to be made, or which are of great importance or of great complexity, should preferably be written. In general, much less misunderstanding should flow from written communications than from verbal ones, because they are available for constant reference and do not depend upon recollection and impression.

The disadvantages of written communications are that they tend to be more formal than verbal ones, and too great an insistence upon written matter readily leads to undue bureaucracy and an atmosphere in which the letter of the document becomes more important than the spirit of the idea. Written communications tend to be slower and narrower than verbal communications. They are slower because the mere process of writing (which, of course, includes all forms of permanent record) involves delay, and they are narrow because the written word always tends to be more circumspect and more formal than the spoken word.

Verbal communications suffer from the serious defect of impermanence. Whatever passes verbally between A and B has gone forever once it is uttered, and the subsequent effect of the verbal exchange depends entirely upon the good faith and recollection of A and B. Either quality in either person may be imperfect and so verbal communications should, in general, be limited to clear-cut and straightforward issues which will not involve constant reference back after the event.

Nevertheless, verbal communications are ideal in many circumstances. In addition to the advantage of informality already mentioned, verbal com-

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Mr. Hill is superintendent of the 550 bed General Hospital, Northampton, England; secretary to the Northampton hospital group, and past president of the Institute of Hospital Administrators. All his career has been in hospital administration, except for two years when he was associated with UNRRA in Germany. In this post, he worked closely with American servicemen and staff members of UNRRA, and that, he says, is how he came to know the language! "The Personality of an Administrator," by Mr. Hill, appeared in *The Modern Hospital* in October.



## DEMOCRACY IS WHAT WE STRIVE FOR, BUT AUTOCRACY GETS THINGS DONE

**H**UMANATION," democratic-participative management and similar theories of corporate personnel practices are ideals to be strived for, says Robert N. McMurray, a Chicago consultant writing in the January-February *Harvard Business Review*, but, human nature being what it is, he proposes a benevolent autocracy as an intermediate step more in keeping with the cold realities of today's life.

### SABOTAGE PRODUCTION

Indeed, not only are many workers unwilling or unable to make a positive effort to contribute to the productive process, but nearly every plant has a group whose positive effort is directed toward sabotaging the productive process, Mr. McMurray holds.

Four major factors that work against the theories of democratic management are cited.

A major premise of the theories is that the principles must be accepted throughout the organization. A top management made up principally of hard driving, egocentric entrepreneurs finds it difficult to accept, let alone implement, such a concept.

Also, the modern commercial enterprise is so delicately balanced that the smallest decision made hundreds of miles from the home office can set up a chain reaction that will affect major policy matters. Faced with this possibility, management is loath to delegate decision making power.

In addition, democratic management theories run counter to the bureaucratic traditions of most companies. So strong are the pressures to "live by the book," that any group of 100 employees, if not carefully controlled, will turn into a bureaucracy within five years.

Finally, when the theories are put on trial, top management has learned, to its dismay, that the employees will use the opportunity to fight against any decision or discipline, and concern themselves almost solely with their "rights."

Organizations that have made an effort to push decision making power onto lower echelon person-

nel have found that constant pressure from above is necessary to maintain the plan. When decision making is permitted to find its natural level it will rise at once to the highest possible echelon, the article postulates. As President Truman said: "Only at my level did the 'buck' really stop."

It can also be observed in organizations that have tried to adopt democratic management that agreements reached by groups are often spurious agreements—that too often members of the group expressed approval of a program they actually resisted. In large, bureaucratic organizations individual autocracy has been replaced by group autocracy in such instances, says Mr. McMurray.

Despite these drawbacks, the democratic-participative philosophy of management has much to recommend it and, with modifications to cushion some of the drawbacks mentioned, can be installed as a benevolent autocracy.

The article lists two further premises that must be considered before this is possible.

### TWO TYPES OF AUTOCRAT

Two types of autocrats must be recognized: the strong, aggressive type who fails to give much thought to his employees because he has learned by trial and error that the autocracy is the best way to get things done, and the weak, bureaucratic autocrat who adheres compulsively to prevailing practices, procedures and policies. If a system of benevolent autocracy is to be installed, it is assumed that at least the top executives will be strong autocrats. They will function like the football quarterback: willing to discuss broad strategy with the line before the game but crisply calling the plays during the encounter.

The second assumption that must be made is that most employees do not want to improve themselves, are not ambitious, do not want responsibility. They simply want a safe, secure job and somebody to tell them what to do.

Acknowledging these points,

what steps should be taken to install a benevolent autocracy?

The first step suggested by the author is to proclaim the desirability of a democratic management in order to create an unfavorable climate for an absolute autocracy.

Second, an inventory must be made of existing executive and supervisory personnel in order to find those who can adapt to the new order and place those who cannot where they cannot block the entire program.

### TELL THEM WHERE THEY STAND

The third step involves the elimination of ambiguity by instituting a job definition and a structuring program. The structuring will define those who are to have authority to make the strategic, policy decisions and the areas in which those who are to make the tactical, problem-solving decisions are to function. This ensures uniformity and provides the employee with both a latitude for decision making that promotes morale and a structure that his demand for security requires.

The fourth step is to make certain that everyone "knows where he stands" with his superior by means of discussions between superior and subordinate based on a statement of supervisory expectations composed of three elements: the job definition, the employee's statement of goals and objectives for the ensuing period (usually one year or less), and the supervisor's statement of what he expects from the employee during the period.

The fifth step involves employee opinion polls taken periodically to ascertain morale and point up legitimate causes for complaint.

Since a realistic appraisal of lower, middle and some of top management today presents a picture which is hardly hopeful for the democratic management theories, this proposal for a benevolent autocracy offers, at best, a technic for "making the best of the worst." It does, however, have one invaluable attribute: Where it has been tried, it works. #

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munications have the tremendous merit of providing scope for discussion. Fine shades of meaning, clarification of doubtful points and, perhaps, even improvement upon original ideas are all readily available in verbal communications and, in many circumstances, this is a much more suitable medium of communication than the more arid written word. It is also through verbal communication that ideas may be pooled and questions may withstand the fire of criticism and debate, and so, despite the defect of impermanence, verbal communications should not be regarded as necessarily inferior to written ones.

Other advantages already referred to are speed, informality and much wider scope, in that many matters of an intimate and confidential nature may be referred to verbally which there would be hesitation in putting on paper. To complete this rough analysis of written and verbal communications, one or two miscellaneous points should be mentioned:

1. Although most situations generally tend to favor one or another type of communication, there should be some flexibility depending upon circumstances. It may be desirable to make a certain communication verbally, but if this is not possible for a few days and speed is essential, then it should be made in writing rather than that time should be lost merely on this ground.

2. Recordings of verbal communications in many ways combine the merits of both written and verbal communications, provided that it is remembered that it is not practicable to record verbal communications upon a large scale and, even if this is done, the permanent record will not be quite so readily available as the visual written word.

3. There is no real distinction in principle between verbal and written communications (a) with one person and (b) with a number of people. While different tactical considerations apply to these various types of communication, the underlying general principles (e.g. as to permanence, formality, and so on) are equally valid where two or more than two people are involved in the communications.

Another possible classification of communications is classification according to the purpose of the communication. From an administrative point of view, this classification is more important than the more obvious distinction between written and verbal communications, and it is one of the first rules of any communication (written or verbal) that its purpose should be clear. Indeed, it does not go too far to say that the quality of

any administration depends very largely upon a clear grasp and the regular use of the principles and techniques in this connection. The various purposes of communications of administrative significance may be broadly summarized as follows: (a) to give or request information; (b) to give or request instructions; (c) to give or request opinion and advice.

Requests for information should not create much difficulty, provided always that the golden rule is observed of making clear that it is the purpose of the communication to request information. This simple rule is by no means always observed and, even upon the simplest issues, needless complication can creep in because, for example, it is not clear whether what is required is information or opinion, or perhaps a bit of each.

#### INFORMATION IS ONLY FACTS

If it is information which is sought, then what is wanted are facts—not opinions, not assumptions, not even ideas, but just facts. The assumptions, opinions and ideas are tremendously valuable if they are requested and given *as such*: It is when they are put forward in a confused jumble and masquerading as facts that they become dangerous. A simple communication requesting information, however, should state clearly what facts it seeks, and even this is by no means common.

If, for example, one wishes to know the number of patients admitted to X County Hospital during the past year, that might sound a simple question and it probably is, so long as that is precisely what is required, but first we should be a little clearer as to what we mean by "the past year." Do we mean "financial year" or "calendar year" or perhaps "records year"? Further, have we been explicit enough in requesting "the number of patients"? Do we wish to know, separately, private patients, general patients, and, perhaps, other special categories, or did we not intend that some of these should be included in the figure at all? Did we wish the sexes to be shown separately and were we perhaps rather hoping that admissions in each separate medical category would be distinguished? Did we mean children to be included in the figure, and what about newly born infants? Are they "admissions" for the purposes of our inquiry?

Finally, have we given any thought to the way in which X County's records are kept? Have we asked for figures from July to June when their records run from January to December, and if so, would the period of their records which they can readily give sufficiently suit our purpose in-

stead of the needless labor of extracting special figures? These are a number of valid questions upon an apparently simple request for information, and very many more could be added without going into ridiculous detail. From these questions, one or two operational principles may be adduced.

1. Anyone who requests information should be absolutely clear what he wants and should state it with sufficient precision for his needs to be apparent to the person giving the information.

2. If the person requesting information is not absolutely clear as to the type of information readily available to the person from whom it is requested, he should try to indicate where information alternative to that requested may be given. For instance, in the foregoing example, if the inquirer merely wants a fairly recent year's record of admissions, he should ask, not for "January to December 1956" but for the last complete recorded year of admissions. If, however, (for example) he is doing a paper on sickness in the locality for the 1956 calendar year, then obviously he cannot concede this particular point and must have figures for the year in question.

3. Requests for information quite often would really welcome general opinion and advice, but neglect to say so. This point should always be made clear, and it is generally of value to state the general purpose for which the information is necessary and to invite the person submitting it to give any additional information which appears to him to be relevant and any general opinion or suggestion.

Rules governing instructions are in many ways similar to those mentioned regarding information, and once again the keynote is clarity. If it is intended that an instruction should be issued, then it should be made clear that the communication *does* constitute an instruction and is not just a piece of advice or information. The point which distinguishes an instruction from the other types of communication is that it involves *action*.

There is the widest of all possible gulfs between the piece of paper or verbal message which merely tells you something which is of general interest and the piece of paper or verbal message (to all outward appearances so similar) which instructs you to *do* something, and there is no end to the administrative confusion which can arise where communications which are intended as instructions do not clearly emerge as such.

It is then imperative that any communication which is an instruction should be in such a form that it could not possibly be mistaken for anything

else, and again, a number of useful operational principles may be adduced as follows:

1. Not only should it be clear that an instruction is being given, but it should be clear precisely what the instruction is. This implies that the sender of the communication must be familiar with the background of the recipient of the communication and, in the circumstances in which instructions are issued (unlike requests for information), this should be a fair assumption. Regrettably, the assumption is not always justified and the issue of instructions which, for one reason or another, cannot be complied with is a fruitful field of administrative misunderstanding.

2. The sender of the instruction should ensure that the action required is within the competence and authority of the recipient of the instruction. In other words, the sender must make sure not only that the instruction is capable of being complied with (the point mentioned in No. 1 just preceding), but also that the person to whom it is sent is the right person to effect such compliance. Again, frequent mistakes occur where subordinates run into trouble in trying to deal with something beyond their competence and authority merely because a superior has asked them to do so.

It is true that some responsibility rests with the subordinate, who should not attempt matters beyond his competence, but the main responsibility rests with the sender of the instruction, who has neglected to observe the importance of making sure that the instruction goes to the right person.

#### GIVE SOME BACKGROUND

3. The sender of the instruction should give sufficient information with the instruction to enable the recipient to act sensibly and responsibly. Care must obviously be taken to ensure that the sharp edge of clarity upon the instruction itself is not diminished, but provided that clarity is maintained, it is, in general, a good idea to give some indication of the background and purpose which motivates the instruction. Except for workers at the lowest levels where any extraneous matter might be a source of confusion, it is broadly true that people respond more intelligently if they are told not only what to do, but why it is to be done. There are countless examples of the advantage of giving a reason for action, and a great deal of progress may be ascribed to suggestions emanating from recipients of instructions who are able to look beyond the instruction to its purpose and to suggest some more rational procedure.

As stated, this must be kept in perspective, as the scope for initiative and enterprise in complying with the usual run of instructions is by no means wide, and for the average worker it is better that instructions should be complied with than that there should be too many loopholes which could be pleaded as justification for omissions and poor performance.

4. Although it is imperative to state *what* should be done and desirable to state *why* it should be done, it is, in general, not advisable to state *how* it should be done. This rule must be approached with some caution because in many technical fields and in respect of many workers of lesser skill, it is necessary to give guidance as to how instructions should be complied with. In many cases, however, particularly where the recipients of instructions are of some seniority, it is very much better to leave the method to be employed to the discretion of the recipient of the instruction. Most people work better in their own way, and most people also resent being told *how* to do their jobs.

To stipulate method is, therefore, in many circumstances, construed as an implication that there is a lack of confidence on the part of the person giving the instruction. Even if this is not intended, it promotes misunderstanding and, in general, it should be remembered that those who are constantly performing certain work usually know more about the best method to employ than those who require the performance of that work. Also, much of the interest in any job derives from whatever discretion there is as to how it is performed, and this asset should not lightly be discounted.

Finally, method, provided it is not unduly uneconomic or wrong in principle, is, in general, irrelevant from the point of view of the giver of an instruction. If you instruct the hospital dietary department to serve roast chicken for a given meal, provided the instruction is carried out satisfactorily, the giver of the instruction has no real interest in the methods adopted and he would be unwise to risk irritating those who have the job to do by becoming involved in method.

5. It is, in general, a good idea that the giver of an instruction should have some simple means of checking in due course that the instruction has been duly complied with. This will vary both with the immediacy of the particular instruction and also with the seniority of the recipient of the instruction.

Often a request that the recipient of the instruction should indicate when the instruction has been performed is practicable, but in some

circumstances this might be inadvisable as impugning the reliability of the recipient and a less direct approach is sometimes indicated. Such an approach is quite valid, provided it is made in such a way that the person responsible for carrying out the instruction does not feel that indirect methods are being employed to observe his performance. It would be much simpler if it could be assumed that an instruction, once issued, was entirely disposed of so far as the giver was concerned. Regrettably, in many circumstances, this is not an entirely safe assumption and, therefore, some simple unobtrusive machinery for checking back is desirable.

6. Thus far we have envisaged instructions which pass between chief and subordinate in the usual manner, but these circumstances by no means cover all the cases where communications involving action are concerned and, particularly in the hospital field, action often depends upon communications between persons of equal seniority in respect of whom the more normal "master and servant" relationship does not exist.

#### REQUESTS FOR ACTION

Such communications, although considered "instructions" for the purposes of our analysis (because they involve "action") are perhaps better described as "requests for action" and they display one or two particular features. These requests for action in general invoke a sense of responsibility, co-operation and collaboration rather than the more usual "disciplinary" aspect of instructions passing between superior and subordinate.

In the normal type of instruction A instructs B and if B does not comply, A may reprimand, discipline and probably dismiss him. In a "request for action" C and D may be of equal seniority or of differing seniorities but in different organizations and, therefore, if C requests action of D and D does not comply, C is in no position to discipline or dismiss D, though he might or might not be in a position to "make it unpleasant for him." The point of distinction is that in the first case of the clear instruction, B owes A a duty to perform it, whereas in the case of the request for action, D does not owe any such duty to C. D might well owe to his employing authority the action which C requests, and in that sense, failure to comply might involve him in difficulties, but it is important that this essential difference between "instructions" and "requests for action" should be recognized because the distinction affects the technic of communications.

Requests for action should (in  
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# Take Time to Make Friends With the Public

Not money or high-pressure publicity, but the little acts of thoughtfulness that prove the hospital likes its community determine the success of the public relations program, particularly in the small hospital

LOUIS GRAFF

HOW does the smaller hospital, which has all the problems of large hospitals and then some of its own, establish a public relations program of which it can be proud and which in turn will reflect pride on the local community?

This is not an easy question to answer. Public relations is much more than just doing something. It is a field of endeavor where the best of intentions is frustrated by the poorest of budgets.

Even where it can be done with a minimum of expense, it is time consuming. And time in a small hospital—or large one for that matter—is often more difficult to find than money.

I don't know how much money you have in your budgets for public relations and I am not even certain that you agree it is an endeavor worth the effort and time. So I cannot hand you a ready-made campaign. Even if I were reasonably certain that you were willing to budget some funds for a public relations program, I couldn't outline one for all of you and expect that it would work for

each of you. Local conditions differ, even though there are elements of similarity among them. And a program to be truly well designed must pay some attention to the local differences. What I do know with absolute certainty as true and useful are two general principles:

1. Whether you know it or not, you've got public relations right now. Every institution, organization, group dealing with two or more people has a public. And in the process of dealing with these people—whether you sell them services or products—certain attitudes, opinions, feelings and ideas are generated.

I am always a little amused, secretly of course, when someone announces the beginning of a public relations effort. Chances are that effort began long ago at a very primitive level. Often when someone suddenly decides that the answers to his problems lie in public relations, he fails to realize that his problems lie in public relations, too.

So, everyone has public relations. You can't escape that. You can have either good, fair or poor public relations. The kind of public relations you have is to a large extent in your

hands. The fact of public relations is not.

That's my first point. Now, my second:

2. A lot of good in life is not done principally because of things taken for granted. We can all do a lot of significantly good things for people if we stop taking a lot of seemingly little, insignificant things for granted.

I am every day reminded of the little things I might have done: the telephone call to thank someone for lunch even though I knew my host was trying to sell me something, the smile instead of frown when someone needlessly interrupts my work, the vote of confidence that comes with a pat on the shoulder, the happy regard for a person's family.

These are not public relations tricks. They are good human relations. They require little skill, almost no money, and they can be done on a spontaneous, nonprogrammed basis. They are little thoughtful contributions to a person's existence, and they are inestimable, invaluable contributions to an organization's public relations.

Let's now take these two principles, or observations, if you will, and combine them. Let's make of them a sound, productive basis for a public relations program which will be as good as possible.

You've got public relations now. Whether it is good or bad depends upon how much you are willing to take for granted. And the things you are willing to take for granted are the risks you are willing to run when you go to the public for support and understanding.

The small hospital has a big advantage. It can say to its patients and

Condensed from an address delivered before the Southwestern Michigan Hospital Council, Kalamazoo, October 1957.

Mr. Graff has been director of public relations and advertising for Michigan Hospital Service since March 1956. Under his direction Michigan Hospital Service won the grand award for the most outstanding public relations program of 1957. Prior to his Blue Cross-Blue Shield post, Mr. Graff was associated with the University of Michigan as health sciences reporter, managing editor of the medical bulletin, and supervisor of the medical public relations department. He attended Kalamazoo College, University of Michigan, and University of Chicago.



to its public with an intimacy not possible for the larger hospital: "Look, we are your friend!" And the chances for getting this statement accepted are great because the physical conditions, the psychological climate, the spiritual significance are all there in the little hand the little hospital holds out to the public.

The hue and cry today against medicine and medical care is impersonalism, indifference and scientific objectivity and cost. The trend today is in the direction of concentration, centralization, federalization, call it

what you will, precisely because of the hue and cry. The little man thinks of medicine as some sort of monster whose growth he both fears and needs and this ambivalence diminishes the effectiveness of modern medicine.

The little hospital can be the little man's friend. And it can do so by the simple expedient of a most inexpensive kind of introspection. Out of that introspection should come a list of things-taken-for-granted, and out of that list of things-taken-for-granted should come the determination to consider every single element

in the highly sensitive, highly complicated situation called sickness as uniquely significant.

If we agree that everyone has public relations, and that having it is not in itself good; and if we agree also to the simple expedient of training ourselves not to overlook the obvious, we can now set down for ourselves a general scheme of things which we will call our program.

The purpose of a public relations program is not to have public relations; the purpose is to strengthen those interpersonal relationships in

## "YOU, THE AMBASSADOR," TELLS WHAT EVERY HOSPITAL EMPLOYEE CAN DO

Every hospital employee is, or should be, an ambassador of good will for his institution. This is the theme of the booklet, "You, the Ambassador," which is the core of a year-long educational program of public relations distributed to members of the Michigan Hospital Association.

The pages from the booklet reproduced here emphasize how each employee can "help sick people to be a little more comfortable; help the hospital grow in service to others; help others to understand and appreciate the hospital, and, by so doing, make his own life happier and more rewarding."

In addition to the little book, the educational program kit contains posters, paycheck enclosures, a suggested article for the hospital's house organ, and a "timetable" to help the administrator make the best use of the material.

a recent survey showed that...

...Every **THIRD** patient

does not think that most hospital employees are sympathetic

...Every **FOURTH** patient

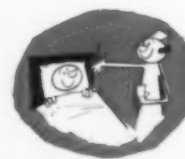
does not think that most hospital employees are trying to provide good care

IN OTHER WORDS, large numbers of people are not favorably impressed either by hospital employees or by the kind of care they are given

HOSPITAL EMPLOYEES KNOW THESE UNFAVORABLE IMPRESSIONS ARE NOT JUSTIFIED



Hospital employees **ARE** sympathetic

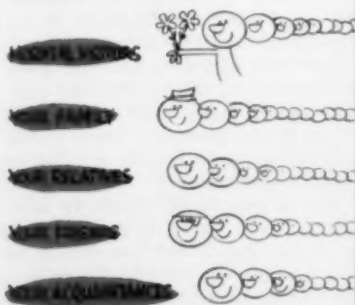


They **ARE** trying to provide good care

But many people do not realize this. The only ones who can change their opinions are hospital employees themselves.

Not only are the patients affected by what you say and do,

but so are...



This means that, time and again...

**YOU**  
are Your Hospital's  
PUBLIC RELATIONS  
AMBASSADOR



WHAT can you do to help give people the right impressions?

Well, first, you can think about our patients



Our patients, of course, are not just "cases"

They are people who are ill, who need care, who have problems.

Decide how you would like to be treated if you were in their place.



Treat each patient the way you would like to be treated

which the hospital is inevitably and inextricably operating, so that sentiment is stronger in favor of the hospital than against it, so that understanding is clearer, so that support is more spontaneous.

That, then, is our purpose broadly stated. Each program in each of your own localities must formulate a purpose which respects the needs of your hospital and the conditions of your community. But let me caution you: Do not be too general. If you feel, for example, that the citizens of your own community are rather well in-

formed in general about your hospital, where it is located, how to find it, when to use it, but you do not feel that there is sufficient understanding of your emergency facilities, your program should incorporate activities which reflect these facilities. If, as another example, you feel that parents are not sufficiently informed of your pediatrics facilities, your general purpose should incorporate that.

In other words, we all agree that we want some good to come out of our efforts, and we want the public and patient to like our hospital. But

unless you differentiate, clarify and specify, you will find yourself doing everyone else's public relations as well as your own because everyone is in the business of doing good today.


So much for the purpose. Now for more specific basic principles which every hospital public relations program should incorporate. Here are three of them:

1. Your program should enlist, as directly as possible, the good will, the respect, and the community support of your hospital.

2. Your program must constantly

## TO GIVE PATIENTS AND PUBLIC A FAVORABLE IMPRESSION OF THE HOSPITAL

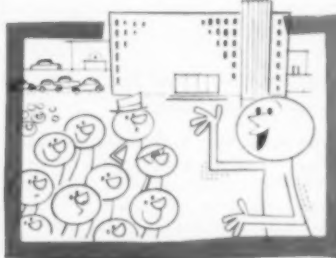
You can think about patients' relatives and visitors.



**THEY ARE WORRIED, CONCERNED.**

Treat them as you would like to be treated if you were a relative or friend.

You can think about others to whom you mention the hospital.




Try to help them understand this busy place where you work. Try to help them appreciate what your hospital means to people in distress.

**YOU CAN THINK ABOUT YOURSELF**

Do you know enough about your hospital to talk about it so that others will understand it?

Can you learn more about it by reading, by asking questions?

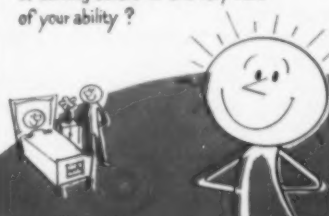
Are you always as kind to patients and visitors as you might be?



Do you move and speak quietly so that patients will not be disturbed by noise?

Do you help hold down your hospital's costs by saving supplies, by avoiding waste? This brings savings to our patients.

Are you getting the satisfaction of serving others to the very best of your ability?




**YES, it means a better life for you and better service to others**

**IF YOU THINK...**

...about how you can do your work in ways that will serve our patients better.

...about how you can make our patients more comfortable.

...about how you can help patients to realize that you are sympathetic, that you do care about their welfare, that you are trying to do your job well.




None of this means that you should discuss the patient's condition or try to give information that only doctors can give.

None of it means that you should try to do special jobs for which others have been trained.

It means that you can make your hospital seem more human in hundreds of little ways that fit in naturally with your own work and life.

**IT'S UP TO YOU**



## RULES FOR HANDLING NEWS ABOUT PATIENTS

### Information Requiring Consent

Since actual hospital and medical records are universally held as confidential, the hospital may not legally release such information without the written consent of the patient and the attending physician.

#### PHYSICIANS' NAMES:

In consideration of personal ethics the name of the attending physician should not be released without obtaining his permission.

#### PHOTOGRAPHS:

The hospital should not permit photographers to take pictures of patients without the written consent of the patient and the attending doctor.

### Information Not Requiring Consent

Hospitals can cooperate with the press by providing the following information WITHOUT THE PATIENT'S CONSENT in accident and police cases which are a matter of police record.

#### IDENTIFICATION:

Name and address (verify for accuracy)  
Sex  
Marital status  
Occupation  
Time and admittance to hospital or emergency service  
Employer  
Name of parents (in case of birth)  
Name of next-of-kin (cases of death)  
Name of mortician (cases of death)

#### NATURE OF ACCIDENT:

If a patient is allegedly injured by automobile, explosion, hunting, shooting, etc., for example, the hospital may state that the patient was injured by a knife or sharp instrument, or that there was a penetrating wound, but may NOT say whether it was a situation of assault, accident or self-inflicted. Explain to reporters that this information must come from police, medical examiner, or coroner.

#### DESCRIPTION OF INJURIES:

Only general information regarding injuries may be made.

#### INJURIES OF THE HEAD:

A simple statement may be made that injuries are of the "head." The word fracture should not be used unless confirmed by the attending physician.

#### FRACTURES:

If it appears a fracture may be involved, do not describe it in any way except to state the member involved, such as leg, arm and so on.

#### INTERNAL INJURIES:

It may be stated that there are possible

internal injuries, but do not specify the location. If very serious, a statement may be made to that effect.

#### UNCONSCIOUSNESS:

If the patient appears unconscious when brought to the hospital a statement may be made to that effect. However, the cause of unconsciousness may not be given. This again is information which the reporters should obtain from the police.

#### BURNS:

A statement may be made that the patient is burned and the member of the body affected. A statement as to the degree of the burn and cause can be made only when the facts are known. No prognosis should be given.

#### PATIENT'S CONDITION:

A statement may be made as to the general condition of the patient using the following classifications, minor injuries, good, fair, serious or critical.

#### DEATH:

A death of a patient is presumed to be public property, and such information may be released to the press.

### Information That May Not Be Given

Because of a difficulty in diagnosis, the time involved in making a diagnosis, and the possibility of repercussion in the form of damage suits, details involving the following types of accident cases should not be released by the hospital. In these cases the hospital should refer inquiries it is not permitted to answer to the medical examiner, coroner or to the police.

#### INTOXICATION:

No statement may be made as to whether the patient is intoxicated or that the accident was due to intoxication, or otherwise.

#### SHOOTING OR STABBING:

No statement may be made as to how the accident occurred, or whether it was an accident, suicidal, homicidal, or in a brawl, nor may the environment be given under which the accident occurred.

#### SUICIDE OR ATTEMPTED SUICIDE:

No statement may be made that there was a suicide or an attempted suicide.

#### POISONING:

No statement may be made that the patient is poisoned. No statement concerning motive, suicide or accidental, may be given and the name of the poisonous substance may not be used.

#### DRUG ADDICTION:

No statement may be made that the patient is a suspected or confirmed drug addict or that the accident was the result of drugs. In all cases where moral turpitude is involved, the hospital again should refer inquiries to the police, medical examiner, or coroner.

emphasize your nonprofit character and your unflinching adherence to the public interest. This involves two things:

You must constantly evaluate the level of understanding of your patients and your public. And you should regularly remind them that you are doing this. I am not suggesting any complicated poll or surveying device. I am suggesting simple telephone calls to sensitive and alert people in your community, asking their opinions and advice. I am also suggesting regular rounds of patients to ask them how they feel and whether they need anything.

You must demonstrate a willingness to reevaluate standing policies and practices in accordance with reasonable public expectations. And if you change a policy in the public interest, announce it.

3. The third basic principle of your public relations program is to keep the first two ever alive through a continuous, or as nearly continuous as possible, use of all the available mediums of communication.

We have thus far discussed our broad purpose, and three specific basic objectives. Let us now turn to the third major ingredient of our program. Perhaps we can best put it in the form of a question.

### CONSULT THE COMMUNITY

Outside your own administrative staff and your board members, have you ever called in other key representatives of your community to discuss your major public relations problems? This, of course, first requires a critical study of your problems, but of equal importance, it requires discussing these problems with community representatives, one or two of whom might just be strategically capable of helping you solve them.

What are some of these problems? You must know them, be able to identify them, before you can hope to begin to tackle them. While the list is by no means adequate, here are a few I can contribute to your stockpile:

1. Getting adequate support from people already overwhelmed with requests.

2. Insufficient awareness of the difficulties of running a modern hospital.

3. Remoteness of community leaders, as well as their little coterie of followers, from the hospital as a community service.

4. Lack of funds, in spite of Blue Cross and grants, to keep hospitals flexible enough to meet today's pattern of rapid change.

5. Difficulties in acquiring and maintaining competent staff and personnel.

(Continued on Page 62)

Reprinted from "Tell Your Story," a public relations handbook published by Michigan Hospital Service, Detroit.

# Instruction Cards Allay Patients' Fears


Patients are responsive to these cards, delivered to their rooms, which describe their part in the procedures scheduled for them. A light approach to the story, colored cards, and professional artwork help the effect

MORTIMER W. ZIMMERMAN

## X-RAY STEPS ARE LISTED

FRONT

NAME \_\_\_\_\_  
ROOM \_\_\_\_\_



Your doctor wants a  
**PORTRAIT**  
of your interior

We want it to look pretty so follow these instructions

1. You will be served supper. Relax and enjoy it. We're all your friends.
2. After supper you must not smoke or take anything to eat or drink from midnight until late tomorrow morning or early afternoon when your test is completed. (NOT EVEN WATER!) Not even your regular medicine.
3. You may receive a cathartic before supper. Later tonight you may be given an enema and another one in the morning. These will be ordered by your doctor to make your interior more photogenic for certain tests.

Good


BACK

4. In the morning you will go to the X-Ray room where our trained technician will give you either one glass of barium to drink, or a barium enema.
5. X-Rays will then be taken.
6. If you have had a barium enema, a final X-Ray will be taken after it is expelled. If you drink the barium, you may get several X-Rays and then return to your room. Later in the morning or early afternoon you will return to the X-Ray room for final film. THEN

**RELAX and ENJOY YOURSELF**

7. You may now eat, drink and be merry!

If you have any questions ask your nurse.



Louis A. Weiss MEMORIAL HOSPITAL • 6848 NORTH MARINE DRIVE • CHICAGO 40, ILLINOIS

FEAR of the unknown can give the hospital patient many uneasy moments, even regarding relatively simple and routine procedures. At Louis A. Weiss Memorial Hospital, Chicago, reassuring instructions presented in the form of cheerful, colorful cards became a part of the hospital's program of patient relations, with marked effect on the attitude of patients, hospital personnel, and doctors.

Six separate instruction cards, in use since August 1957, make the basal metabolism, blood chemistry, gallbladder and intestinal x-ray tests less of a mystery to patients; explain the necessity of a special diet or offer Kosher food service if it is required and medically approved, and prepare patients for preoperative and postoperative procedures.

This current series, utilizing professional art work, colored paper stock, and carefully prepared messages of a light-hearted nature, is the second pioneering step made by Weiss Hospital in this field. In 1953, when the hospital first opened, mimeographed instruc-

MORTIMER W. ZIMMERMAN, executive director of Louis A. Weiss Memorial Hospital, Chicago, was in personnel work for five years, at the University of Chicago and as a partner in his own consulting firm, before he went to Northwestern for his graduate work in hospital administration. While studying, he worked as personnel administrator of Passavant Memorial Hospital, Chicago, and on graduation assumed his present post.

## PATIENTS LEARN WHAT TO EXPECT AND WHAT IS EXPECTED OF THEM

tions were prepared in order to accomplish a similar objective.

Since the new cards have appeared, patients have received them enthusiastically, regarding them as pleasant souvenirs of a hospital stay. The first checkup on patients who had received the cards before undergoing their procedures revealed that one-half of the patients questioned concerning their instruction cards had already packed the cards in their suitcases. Several patients asked for more, even though they were not contemplating further tests. One young man said he was going to frame them for his study at home!

Response of all who are affected by

this new approach shows a great variety of purposes served. The instructions, by giving the patient some idea of what to expect, lighten his apprehensions and impart to him a deeper feeling of security. Also, he usually appreciates the hospital's interest in his welfare and frame of mind. Exploiting the humorous aspect helps further in relaxation, and the total effect is one of complete cooperation on the part of the patient.

This in turn has a good effect on the hospital employees who deal with these patients. Nurses in particular are pleased to work with the patient who has been enlightened and entertained. Members of the medical staff, all of

whom received copies of the instruction cards upon publication, have commented most favorably upon them.

The various instruction cards are kept in the nursing station, where the name and room number of each patient who is to have one or more cards are filled in as the medical requisition is received. The appropriate cards are delivered to patients by nurses during the night before the procedures.

From the success of this project, it is possible that similar cards will be added to the present set of six if it is found that this medium will be helpful in giving patients information and reassurance on subjects not now covered. #

## PATIENT PREPARED FOR SURGERY

### FRONT

NAME \_\_\_\_\_  
ROOM \_\_\_\_\_

You are about to join a very  
*Exclusive Club...*

Your doctor wants you to be fully aware of how painless the "initiation ceremonies" will be for your membership in the  
*"Did I Tell You About My Operation Club?"*

1. You will receive dinner about 5 P.M. the night before your operation.
2. Enemas may be ordered following evening meal. Skin area around the area to be operated on will be shaved. This will be done the evening before surgery. However, in some cases it may be done in the morning before surgery.
3. A sleeping pill may be ordered for you in the evening if you need it.
4. You will not eat or take anything by mouth after 12:00 P.M. if you are scheduled for surgery the following morning.
5. Ladies! The nurse will ask you to remove your nail polish, jewelry, hair pins and makeup.



*Issued*

### BACK

6. About one hour before surgery, you will receive a hypodermic, a hospital gown and a surgery "hairdo".
7. You will then be on the way to surgery.
8. After surgery, you will be taken to the "recovery room" where you will get special attention until you awake. Your family will be notified of your progress in the recovery room.
9. After you are awake, you will be returned to your freshly made bed.

If you have any questions ask your nurse



*Louis R. Weiss* MEMORIAL HOSPITAL • 4848 NORTH MARINE DRIVE • CHICAGO 40, ILLINOIS

## B.M.R. TEST WILL TAKE TIME

### FRONT

NAME \_\_\_\_\_  
ROOM \_\_\_\_\_


let's see how lazy YOU can be!

**YOUR DOCTOR HAS REQUESTED A  
BASAL METABOLISM RATE TEST FOR YOU**  
(also known as a "Breathing Test")

You must have absolute rest.  
PLEASE FOLLOW THESE INSTRUCTIONS

Your nurse will explain the test to you. There is no pain or discomfort involved in the examination at all. To be relaxed so the test will be effective, you must cooperate down to the smallest detail.

The test is easy. So take it easy. All you have to do is breathe pure oxygen through a tube in your mouth while your nose is clamped shut.



*Issued*

### BACK

1. After midnight before the test you must not eat or drink anything but water. You must remain in bed. No smoking. You may go to the bathroom if permitted; ask your nurse.
2. You will not be served breakfast until the test is finished.
3. If you are in a semi-private room, the curtains will be drawn around your bed. The door to your room will be closed until time for your test, if your room is private.

YOU MAY NOT HAVE VISITORS.  
YOU MAY NOT GET OUT OF BED.  
YOU MAY NOT READ OR SMOKE.  
YOU MAY NOT PLAY THE RADIO.  
YOU SHOULD LIE QUIETLY IN BED.

**4. (BREATHING IS PERMITTED!)**

5. In the morning you will be taken to the laboratory in a wheel chair. The technician will weigh you when you get to the laboratory. You will have to rest about 1/2 hour in the laboratory before the test will be started. Please be patient while waiting for laboratory personnel in the basal metabolism room, and with the kitchen where your breakfast will be prepared as soon as you finish your test. There are a number of patients having similar tests, so all this may take a little time.

If you have any questions ask your nurse

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## BY MEANS OF THESE CARDS WHICH TREAT SERIOUS SUBJECTS LIGHTLY

### DOCTOR ORDERS A BLOOD TEST

FRONT

NAME \_\_\_\_\_  
ROOM \_\_\_\_\_

Your Doctor wants a *Portrait*  
of your blood tomorrow morning...

We want it to look pretty...  
so follow these instructions

1. You will be served supper. Relax and enjoy it. This is easy.
2. At midnight you will not turn into a pumpkin, but from that time on you must not eat or drink anything until the test is finished in the morning. And No Smoking! If you are very thirsty you can take a small sip of plain water.

And no fair cheating!



BACK

3. Do not eat or drink anything in the morning. After the test the kitchen will be notified to prepare your breakfast.
4. Our trained technician will take tiny samples of your blood for special blood chemistry tests. You will feel only a slight "pin prick" in your arm when the sample is taken.

THEN  
RELAX and ENJOY  
YOURSELF

5. You may now eat, drink, and be merry! Be patient while waiting for your breakfast. Many patients are having similar tests so it will take a little time to prepare your food.

If you have any questions ask your nurse



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### GALL BLADDER TEST EXPLAINED

FRONT

NAME \_\_\_\_\_  
ROOM \_\_\_\_\_

Your doctor wants a *Portrait* of  
your Gall Bladder tomorrow morning

We want it to look pretty...  
so follow these instructions

1. You may be given a cathartic in the early afternoon or you may be given an enema after supper (as ordered).
2. You will be served a non-fat supper.
3. After supper you will be treated to "The Parade of Pills." You take them every five minutes until all ordered have been given. They make your gall bladder show up in an X-Ray.
4. Do not eat anything after supper! Drink water only.

And no fair cheating



BACK

5. Do not eat or drink anything after midnight—not even water—until your X-Rays are completed.
6. So far it has been easy, and it gets even easier. The X-Ray department will call for you when they are ready to take your X-Rays. Now, several pictures will be taken of your gall bladder.
7. Next you will get something to drink in X-Ray. This will make your gall bladder ready for the last picture.
8. Back to the Radiologist for final X-Rays... then...

relax and enjoy yourself

9. You may eat, drink, and be merry. Please be patient while waiting for your meal, as there are many patients having similar tests and it takes a while to prepare your food.

If you have any questions ask your nurse

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### SPECIAL DIET IS INDICATED

FRONT

NAME \_\_\_\_\_  
ROOM \_\_\_\_\_

Your prescribed diet is \_\_\_\_\_

Your doctor has placed you on a *Special Diet*  
as part of your medical treatment

We'll do everything we can to make mealtime enjoyable, but we need your cooperation. We think you should know:

1. Cooking a special diet is just like filling a medical prescription. We follow your doctor's orders and so should you. Please stick to the diet he prescribes. You'll get well faster.
2. Our friendly dietitian will visit you after you're comfortably settled in your room. You will be asked to tell her what you prefer to eat. You may not always get the foods you like best. Your food may not be seasoned just as you prefer. But we try to make mealtime something to look forward to.
3. Remember, the dietitian already has your doctor's order about what you can and cannot eat, when she visits you.

If you have any questions, please ask your nurse to contact the dietitian.

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BACK

NAME \_\_\_\_\_  
ROOM \_\_\_\_\_

*Kosher Food*

If you want kosher food, and your doctor approves of the meals for medical needs, we'll be glad to serve you. We'll do everything we can to make mealtime enjoyable, but we need your cooperation.

We think you should know:

1. You will be served strictly kosher meals prepared under rabbinical supervision. But NO SUBSTITUTIONS PLEASE! Our kitchen is not kosher. The kosher meals you will eat are prepared by a specialty restaurant. They are pre-packaged, frozen meals just like the TV-dinners sold in the grocery stores, except that these are kosher.
2. Each meal contains meat or fowl, potatoes and vegetables and a beverage, or a dairy meal—eggs, fish or cheese as entrees.
3. Your kosher meal will be served on special dishes and will have a special knife, fork and spoon. These dishes and utensils meet religious requirements, too. They come all ready for your use when your meal is packaged. And like paper plates, they are thrown away after you have finished eating. You may not always get the foods you like best. Your food may not be seasoned just as you prefer. But we try to buy meals that are interesting and appetizing for you.

If you have any questions, ask your nurse to contact the dietitian.

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## Take Time to Make Friends With Public

(Continued From Page 58)

6. An antiquated, dry-goods store type of internal education and communication with staff and personnel.

These are just some of the hospital's problems. They may be typical; they may not. But they at least represent someone's efforts to put them down on paper. This is what I suggest each of you do in your own local circumstances. I also suggest that your efforts to improve relationships with the public will succeed only if you analyze and characterize as specifically as possible the nature of these relationships.

Finally, after our purpose, objectives and problems have been defined, comes technic. Here I am willing to go way out on a limb.

### GIVE TIME TO THE PROGRAM

You all know how long it takes to build up a good sound relationship with someone. Years of confidence, loyalty and service go into building a friendship. How many pounds of sugar go into winning a neighbor? You also know how long it takes to restore confidence once it is broken. And how quickly the sugar is forgotten when a baseball flies through a kitchen window! These relationships take time to construct, and they take much more time to reconstruct. You must be willing to donate this time. There is no other way.

Therefore, whatever are the technics, the activities, they must be conceived in terms of their impact on the time-span. Many brilliant ideas are born in a split second, but in terms of their impact on the totality of human relationships, brilliance gives way to durability.

With patience and a single weekly newsletter to trustees you have a chance of establishing a sound relationship which cannot be matched by the most engaging, professionalized promotion stunt imaginable. It is not how many technics or activities you carry on that counts as much as how regularly, continuously, consistently you utilize what technics you have.

Thus, any consideration of the implementation of your program must allow at least five years. It is not an overnight proposition; it is every day. I feel that nonprofessional public relations people are too quick to look for results. Actually you may never have the satisfaction of seeing results; you are doing what you believe is right, is in the public interest, and good in itself. The results of public relations are often within you rather than outside you.

Let us now implement. Here are some suggestions as to how to get the most from the least:

1. You would do well to establish a public relations council in your hospital, attended monthly by representatives both from within the hospital and from the community at large.

2. You, the administrator, must pledge complete interdepartmental cooperation and administrative enthusiasm. Nothing kills a public relations effort faster than cynicism and indifference.

3. The local hospital should constantly emphasize in its publicity the many nonfee community functions it performs with young people, as a research center, as the locus of religious inspiration, and for the medically indigent. This means, of course, that you as the administrator must sit at the window of your community and watch silently to detect the things that interest your particular citizens. Then you must discover a means of satisfying that interest, if at all possible, through the hospital.

4. Develop, within your means, simple and graphic printed material which will explain the various services available in your hospital. In preparing it you should keep in mind the patient's great need to know *why* things are run the way they are. Some hospitals send a brochure to expectant mothers along with an advance admission form. The husband or wife fills out the form in the leisure and comfort of the home, thereby circumventing a procedure no one relishes when pain, excitement and fear are present. I shall never forget our experience at a large metropolitan hospital at the birth of our second child.

The nurse said to me, after we had finished the very labored execution of the admitting form, "Well, say goodbye to your wife, Mr. Graff. This is the last time you will see her."

5. This leads to my fifth point of implementation: Train, train, train all of your public contact people not only in the amenities and the proprieties but in the psychology of illness as well. I dare say this is the most critical area in all of your public relations—a bad voice on the telephone, a curt reply at the information desk, an unpleasant manner in the elevator. These are not silly, childish considerations; they strike at emotions already burdened with anguish and terror.

Your patient is a child. He may be dirty; he may be rich. He may be a malingeringer; he may be half dead. He may be important socially; he may be a skid row derelict. But he is your patient, and he has come to you for help.

Your people should be trained to

be proud to have the chance to help these people, and they should learn how to repay them by exchanging small tokens filled with gratitude and understanding.

6. Use your newspapers to report events both as news and as human interest features. But I have a word of caution to offer here. You are in a limbo between your patient, whose privacy you must respect and guard, and your newspaper reporter, whose job you must recognize and understand. This means that you must maintain a delicate balance between two compelling interests. Your first obligation is your patient and his welfare. But this does not mean that you have the right to stand between him and the world he lives in. I have never known a reporter who failed to respond understandingly to an administrator who stood firmly, tactfully and honestly on the ethics of his profession. But too often I have seen reporters needlessly alienated by the administrator who was belligerent, uncooperative or dogmatic. A newspaper reporter is a bad adversary; he holds the type!

### MAKE IT A HEALTH CENTER

7. Finally, to implement a modest program in your community, you will find it immensely profitable in terms of public relations if you try to relocate your hospital in the community mind. By this I mean, promote the notion that yours is a community health center, not an asylum. Sweep the dust of death from your corridors, and open your doors to people in your community who need a meeting place. Cooperate with the school system on health matters. Stage exhibits, forums and lectures on matters of the positive side of health that interests the public so vitally today. Today's hospital is a health center where prevention is just as important as palliation and cure. Begin with children. Let them see your magical and mysterious operating rooms; let them try out one of those fancy beds just for kicks, for it is with the young that the strongest attitudes are nurtured.

Getting the most for the least in public relations may well seem inadequate, perhaps even unprofitable. But where human relationships are involved, the least is often all most people expect. And when little things are done for sick people, you have transformed the thing-taken-for-granted into an act of unexpected, gratifying thoughtfulness. Ultimately, your public relations program will be as successful as you want it to be. Ironically enough, whether you succeed depends not so much on the public's liking you as upon your liking the public. #

# Hearings Foreshadow Crisis for Blue Cross

Issues raised in New York and Pennsylvania show that  
there are questions about the rate increases now  
being sought and about representation in Blue Cross

MICHAEL M. DAVIS

PUBLIC hearings lately held by state insurance commissioners in three cities in two states turned out to be much more than formal proceedings about raising Blue Cross rates. They have brought to the surface deep-seated trends and conditions which are not confined to New York and Pennsylvania, but which are widespread in the United States: trends and conditions which impair the growth and may threaten the life of Blue Cross if not taken vigorously in hand.

## RATE HIKE OPPOSED

Our largest Blue Cross plan placed itself on show last November on the occasion of a public hearing, called by the New York State insurance commissioner to consider the Blue Cross request for a 40 per cent increase in rates for the coming three years. Blue Cross had decided upon this rise without consulting important organized groups constituting a substantial proportion of its subscribers. What happened? Local unions opposed the increase on the ground that no such large jump was necessary. So did the city government which has more than 200,000 employees in Blue Cross. These opponents questioned the accuracy of the Blue Cross accounting. They attacked the formula used to determine hospital reimbursement. They declared that Blue Cross had accumulated, out of its subscribers' payments, a reserve fund far larger than the amount required by the insurance department, and they criticized the social and economic justification of this policy.

Furthermore, a number of the local unions created a united front, and

engaged an expert to represent them jointly at the hearing. Because the issues concerned Blue Cross subscribers all over the country, the A.F.L.-C.I.O. national headquarters sent an official representative to present a forceful criticism. Continued discussion led the *New York Times* to publish, five weeks later, a leading editorial, of which a small part read as follows:

"Clearly [Blue Cross] has not given its subscribers and the public the status they should have—especially in dealing with the hospitals as to charges. For example, its board of twenty-four directors—a self-appointed body—is heavily overweighted with representatives of the hospitals and the medical profession. Only one of them can speak for organized labor and none represents the interest of the city government or of its employees. Furthermore, its published annual reports omit a great deal of information essential for judging its operations, such as—incredibly enough—its income and expenditures and its financial arrangements with the hospitals."

Less than a month later, the Pennsylvania insurance commissioner held a similar hearing in Philadelphia, the state attorney general serving as his counsel. Late in January of this year, the same officials began another long hearing in Pittsburgh. The same pro-and-con alignments appeared: Blue Cross and the hospitals *versus* the city governments and the labor unions. Since in these three areas, as in several others in this country, the local membership of Blue Cross comprises

more than half the population, an increase in rates becomes also a public and maybe a political concern, similar to a rise proposed by public utilities in charges for telephones or electricity.

The underlying issue revealed by all these hearings, as in several earlier ones in other states, was the relation of Blue Cross to its subscribers. Is Blue Cross run by hospitals and doctors? How does Blue Cross management represent the subscribers who finance it? How far do the attitudes and working policies of Blue Cross management take subscribers, or organized bodies of subscribers, into counsel and consideration?

The *Times* description of the governing body of the New York Blue Cross would be typical of Blue Cross plans. The Pennsylvania insurance commissioner pursued the issue of subscriber representation at both of his hearings. It was shown that even where, as in one case, subscribers were supposed to share in the selection of board members, Blue Cross had not devised ways of making this policy effective.

This underlying issue was reflected in the long discussions of technical questions at the hearings. Hence, some review of these questions is necessary.

## SEVEN SPECIAL QUESTIONS

1. **Hospital Costs.** The average per diem cost in nongovernmental general hospitals was less than \$4 at the close of World War I. It was nearly twice that in 1944, and was six times higher in 1956. Blue Cross has been caught in a pincers between the hospitals' demand for more dollars to meet rising costs and the subscrib-

ers' resistance to higher rates of payment.

We who are familiar with hospitals know that the basic reasons for rising hospital costs are the elaboration of technology, the increase in employed personnel per patient, and the general trend toward higher wages, salaries and costs of almost all materials and supplies. We know also that these changes have been accompanied by great improvements in medical and

surgical service and have furthermore been largely beyond the control of individual hospitals whose charges are now under attack.

The average American has not been reached—or if reached, not convinced—by the excellent technical explanations of rising costs which have appeared in hospital magazines and reports. Explanations in popular form are often given in leaflets to hospital patients, but come to them or to their

families at an unfortunate time psychologically. Moreover, a basic change in the impact of higher costs has come about with the growth of Blue Cross and other health insurance. In the old days, hospitals billed their patients and collected from them individually. Now over half the current income of all short-term nonprofit hospitals—over two-thirds in many hospitals—comes from well people through group payment—insurance or taxation. These

## GOV. HARRIMAN'S MESSAGE TO N. Y. LEGISLATURE ON BLUE CROSS

THE growth of nonprofit, prepayment hospital and medical care plans since their inception about 20 years ago has been phenomenal. By the close of 1957, almost 9 million residents of our state were covered for hospital expenses under Blue Cross plans, and nearly 6½ million for medical and surgical services in hospitals under Blue Shield plans. The use of the prepayment idea to meet unexpected and costly health bills has gained acceptance because it effectively meets a real need. These plans are now as much of a fixture in our society as other forms of insurance.

As in all rapidly expanding operations, this growth has not been without its problems. When the statutes governing these corporations were first written into the insurance law, we were dealing with an untried and interesting innovation. Today, we are dealing with a large-scale operation that has widespread social and economic effects. As a natural consequence, the laws governing these plans are in need of modernization.

In a recent decision disapproving an application by the Associated Hospital Service (Blue Cross) of New York, for an increase in subscriber rates approximating 40 per cent, the superintendent of insurance indicated that, in several significant respects, the operations of these plans were beyond his purview. He also indicated the need for a change in the statutory requirements relative to the maintenance of a contingent surplus fund. Legislation has been introduced to permit a reduction in these funds. The moneys so released can be used to pay claims and expenses. This proposed change will permit a greater degree of flexibility, while at the same time recognizing the needs of the plans

to be able to meet unexpected contingencies. It will also permit requests for changes in subscriber rates to be determined by the superintendent of insurance on a more realistic basis.

I recommend that this legislation be approved. If it is not, a considerable increase in Blue Cross rates in New York City will be inevitable within a very few months.

### STUDY RECOMMENDED

In order to enable the superintendent of insurance to deal on a fully informed basis with future rate problems, it is important that a careful study of Blue Cross and Blue Shield operations be undertaken by highly qualified personnel. This study should encompass the following areas, among others:

**1. Costs of administration and efficiency of operation of Blue Cross and Blue Shield plans throughout New York State.** Questions have been raised as to possible reductions in operating costs and more efficient operations. Information on these subjects is basic for any future review of applications for subscriber rate increases.

**2. Coverage of plans.** Costs of services are directly related to types and quantity of services rendered, including outpatient and emergency services. One important question which has been raised in this area is whether costs of mental illness should be included.

**3. Excessive use of hospital services.** This is a knotty problem and involves the medical aspects of the whole program. A study should be able to produce recommendations for methods of combating excessive use, if it is found to exist.

**4. Regulatory powers to be vested in the superintendent of insurance.** The superintendent now has full authority to approve or disapprove subscriber rates, but his authority

over the charges made by member hospitals for services rendered is limited.

**5. Requirements with respect to representative character of boards of directors.** In view of the fact that these plans are of a quasi-public character, the question has been raised whether their boards of directors should not be more widely representative of the subscribers.

At no time since the plans were introduced in the 1930's has there been a thorough review of their operations, conducted by an impartial body. Such a study should make it possible to provide a sound basis for review of future applications with regard to subscriber rate increases.

If this study is authorized, I will ask the commissioner of health, with the advice of the superintendent of insurance, to set up an advisory committee representative of all interested parties—the public, the medical profession, hospital authorities, health insurance administrators, labor organizations, and other interested groups. This advisory committee will serve to assist in the planning and review of the work of the university staff of experts that will carry out the study.

I am confident that such a study will be welcomed by the health insurance plans, the public and the allied medical and hospital professions alike. It is an immediate necessity, if we are to face our public responsibility of developing a basis for determining a sound rate structure early in 1959 for subscribers to Blue Cross and Blue Shield plans in New York State.

I therefore recommend legislation authorizing the department of health to make such a study and appropriating \$100,000 to it for that purpose. —Averell Harriman

people furthermore—especially in the industrial areas where Blue Cross has been strongest—are functioning through organized groups whereby they can express themselves effectively. Previous hearings in several states, notably Michigan, had shown that organized public expression by Blue Cross subscribers was on the march. The recent hearings dramatized subscriber expression on a larger scale and at a higher temperature.

2. **Adequacy of Blue Cross Data.** Requests for a rate increase, submitted according to state law to a public official, are of course accompanied by extensive financial data. The adequacy and accuracy of these data were questioned; there have been questions of good faith as well as of accountancy. Those familiar with the regulation of public utilities will be reminded of these processes by the Blue Cross hearings. It always becomes evident that accountants are the servants of policy as well as of mathematics.

3. **Blue Cross "Surplus."** At all hearings, especially in New York, the size of the surplus funds accumulated by Blue Cross was in question. The New York commissioner recently issued his decision to deny Blue Cross its desired increase for the present, primarily because of the large surplus it had accumulated. The subscribers' point of view seems to be: "Blue Cross money comes from us. Why should funds be accumulated beyond legal or reasonable requirements of safety, instead of enlarging our benefits or reducing our rates?"

#### MANAGEMENT COSTS QUESTIONED

4. **Management Costs.** Management costs are an issue raised in many places, not merely these three. Subscribers point to large sums in dollars spent for salaries, acquisition costs, and so on. Management replies that, compared with the total volume of operations, the costs of Blue Cross administration are lower than most health insurance plans—down to less than 4 per cent in some of the large ones.

5. **Payments to Hospitals.** The way Blue Cross pays the hospitals is another spot where Blue Cross is pinched between its hospitals and its subscribers. Payment to hospitals of reasonable costs of service seems to most subscriber organizations a fair basis of compensation; but what are "reasonable" costs and just how shall they be determined? There are examples of Blue Cross plans which audit hospital books or assure independent auditing thereof, and there are other examples not so satisfactory. There are hospitals which ask Blue Cross to pay them their charges instead of their costs, thus ignoring the difference between an insurance plan and an un-

insured individual patient. On this point a representative of a large public agency remarked: "Hospitals that ask to be paid their billings should get no cooings from Blue Cross." But it is hard for Blue Cross to struggle against hospitals in instances when hospitals are the controlling influences on the Blue Cross governing boards.

6. **Depreciation** is another area of dispute. Hospitals which make an annual depreciation allowance for buildings and equipment, but which do not actually set aside the money to be used when replacement is required, are charged by critics with using a bookkeeping device to pad their current income.

7. **Overuse.** The average length of a hospital stay has been shortened, but utilization increases. A larger proportion of the population goes to hospitals than formerly. More service for a given number of people means higher total cost. How much of this increase is wholesome use of hospital care, previously scamped because economic barriers had not been wholly or largely removed by health insurance? How much is due to a greater proportion of older persons in the population, or to changing social conditions, such as more urbanization? How much is due to abuse of the opportunities for hospitalization provided by insurance: abuse by patients, by doctors, by hospitals themselves? As shown at the hearings, subscriber groups generally blame doctors and hospitals for creating or accepting overuse, and blame Blue Cross for inertia in protecting subscribers by controlling it.

There are indeed promising examples of home care programs pioneered by hospitals; of ambulatory services in some Blue Cross contracts; of visiting nurse service to facilitate earlier discharge. There are Blue Cross leaders who perceive how beneficial it would be to Blue Cross if such examples were multiplied until they became nationwide "movements," pushed vigorously by professional bodies, instead of being pushed on them by lay bodies; but Blue Cross is inhibited by many of its hospitals and both Blue Cross and the hospitals face the policies of most medical societies, emphasized by certain specialists, to restrict the scope of hospital service and therefore of Blue Cross.

Not until the way had been pioneered by Blue Cross and Blue Shield, and until collective bargaining for health benefits had become common, did commercial insurance take hold of the business actively. In 1940, the total enrollment (group and individual) of the insurance companies was a little more than half of Blue Cross' six million. In 1956, however, the

companies' enrollment had risen to 73 million, a twentyfold increase. Blue Cross had attained only 50 million, although its total of benefits paid was slightly larger than the companies'.

Many of the smaller Blue Cross plans and a few of the larger ones have gone over in considerable part to indemnities; but the service principle has been well upheld by most of the larger plans and some of the smaller. Many labor unions have gone in for insurance company contracts. For various reasons, employers often favor these. The amounts negotiated by a union through collective bargaining may begin at a sum which is insufficient to buy the relatively adequate benefits of a good Blue Cross (and Blue Shield) plan, whereas the union can make a health-insurance beginning with a limited cash-indemnity policy, for the sum it has in hand.

Insurance companies generally offer contracts providing lower rates for groups which, because of the age of their members, or other conditions, are likely to have less-than-average sickness. Such "experience rating" is against the basic aim of full population coverage held by both Blue Cross and organized labor, but its lures have led important unions to seek it and Blue Cross to accept it to some degree. Last autumn the New York insurance commissioner issued a decision regarding the excellent Rochester plan, which if maintained would have the effect of requiring experience rating. Expansion of experience rating would mean that high-risk groups—which in many instances, such as aged persons, are also low-income groups—would be stranded without ability to obtain health insurance. Governmental insurance or extension of tax supported medicine is the likely result.

Blue Cross has made a beginning in meeting the demand for nationwide contracts with large employers and large unions, endeavoring to overcome the disadvantage of having some 80 separate Blue Cross plans with varying scales of benefits and rates. The newly established "Blue Cross Association" will further facilitate national contracts and should also provide leadership that sees Blue Cross problems broadly instead of locally.

#### THE BASIC PROBLEM

Lately I have re-read speech after speech, article after article, coming during the last decade from hospital and Blue Cross leaders, pleading for sound policies. Strongly they urge that hospitals should support the principles of service benefits as against cash indemnities, of community rates as against experience rating. Strongly they demand that Blue Cross shall

function as a community enterprise rather than a private business. In general, they inveigh against the pressures which, as James E. Stuart said a couple of years ago, "tend to force Blue Cross to identify itself more and more as an insurance company operation rather than as a service plan to meet community needs."

In both Blue Cross and in hospitals, however, such leaders face a losing fight unless and until they can marshal behind their pleas forces from outside the hospital and the medical world. How many boards of trustees, how many hospital medical staffs accept the importance of programs of ambulatory diagnosis and organized home care and are ready to push such programs vigorously? How many are prepared to insist on firm steps against unnecessary hospitalization? How many will determinedly uphold service benefits and extend them even against the opposition of certain staff specialists? What can even farsighted hospital administrators do against their boards and staffs? What can Blue Cross leaders do when the governing bodies of their plans are weighted the same way? There are Blue Cross plans that have moved forward on these fronts, but these are as yet exceptions.

#### SEPARATE BILLINGS RAISE COSTS

Hospitals on their part have not held their ground, in many institutions and in some whole states, against the efforts of certain specialists, particularly those in x-ray and in anesthesia, to separate their services and their billings from the hospital organization. Several hospital leaders have made clear that these efforts, insofar as successful, lessen the unity of service to the patient and increase costs. On Blue Cross the effect has been to exclude x-ray services from Blue Cross benefits in a majority of the plans, although the larger plans have generally been able to keep them in, and to handicap if not prevent the development of ambulatory diagnosis on an economical basis.

Here we are on the troubled boundary between Blue Cross and Blue Shield. Blue Cross and Blue Shield must both be involved in any solution of the total problem of medical care insurance, but Blue Cross, set up as it is, cannot be expected to take the primary responsibility for redrawing disputed boundary lines. Hospitals and medical societies must share in the task. Moreover, it seems clear that the task will not be performed until people from outside insist that jurisdictional disputes between doctors and hospitals shall not compel the ultimate consumers to get less health insurance than they want and to pay more for what they get.

The critical attitude of subscriber groups at the hearings reflects the feeling that, although their money is inside, they are kept outside. One representative of a large organization said to me: "Why should these Blue Cross men play their cards so close to their chests, with our money, so that we never know what's what until some boost in rates is flung at us?"

Continuing tensions between subscribers and Blue Cross will bring disadvantages to hospitals and possible disaster to Blue Cross. Important groups of subscribers are aware that they have alternatives besides Blue Cross. Some bodies of subscribers could undertake self-insurance; all could move to commercial insurance and try to broaden and otherwise to improve it. Many could unite in political action for governmental insurance, which in some forms might make an important place for Blue Cross.

An immediate and more likely political alternative is broadened state regulation of Blue Cross plans and of some phases of hospital accounting. Such ideas have already been publicized in Massachusetts, raised in some other states, and are now officially above the surface in New York. This February, Governor Harriman sent a message to the legislature, asking an appropriation of \$100,000 for a comprehensive study of Blue Cross and Blue Shield within the state, designed to "provide a sound basis for review of future applications with regard to subscriber rate increases." All phases would be covered—benefits, costs, administrative efficiency, utilization of services, composition of governing boards, scope of state regulation. The governor proposed that the state department of health conduct the study with technical aid from a university and the advisory services of a broadly representative committee. (see p. 64).

#### OPPORTUNITY AHEAD

Might such proposals lead to a Blue Cross that would be stronger because it would unite, instead of keeping separate, those who support it financially with those who keep it going professionally? Blue Cross management has usually regarded its subscribers as customers. It is becoming apparent that they must be treated as partners. But how, in practical terms, can Blue Cross enlist its subscribers as "partners"?

There are Blue Cross plans in which representatives of subscriber organizations—chiefly unions—have been brought into the governing boards; but such representation has gone only a little way and has often been ineffective. There are boards whose charters require that a certain proportion of

the members shall be "public" representatives, but who elect to such posts persons whose close affiliations are with hospitals. "Representation" on Blue Cross boards of "the public," of "labor," or other subscriber groups will accomplish little so long as such persons are taken on as second-class citizens, not admitted to inner councils. Experience has demonstrated that the essential need is a change in attitude on the part of Blue Cross leadership. No great benefit can follow from merely formal alterations in structure.

Will Blue Cross deal with the present uprising of subscriber interest as a threat or as an opportunity? Certainly there is an immediate opportunity for Blue Cross leaders, national and local, to initiate informal conferences with persons drawn from selected subscriber groups. Such meetings should be small gatherings for the definition of areas of common interest and the discussion of common problems, aimed to develop mutual confidence.

#### EMPHASIZE COMMON INTERESTS

Producer and consumer interests in medical care are not the same, but there is a large area of common interest. Shortsighted attitudes have let divergence grow, instead of emphasizing common purposes. Common interests have not been kept in the forefront through sufficient intercommunication. Those who receive and pay for service are directly interested in its scope, quality and economy. The best medical and hospital tradition holds the same objectives.

Blue Cross can be confident that subscribers want to obtain fuller benefits of modern medicine for themselves and their families; that they will support rising costs if, before they are given pills to swallow, they are led to understand through conferences how present costs are derived and just what additional costs are necessary in relation to the benefits to be obtained.

Once the attitudes of partnership were made manifest in informal conferences, national and local, results would follow. Adjustments of governing board composition would appear with the advance of mutual confidence and understanding between Blue Cross management and subscribers. Hospitals, far from being endangered by these developments, would obtain fuller financial assurance and greater support for their community objectives. Financially, Blue Cross is now a billion-a-year enterprise. Socially, it involves 50 million people. An enterprise of such human and economic magnitude challenges all its national and local leaders to approach the present critical problems with fresh minds and to move forward with courage. #

## SURGEONS TO STUDY EMERGENCY SERVICE

**Trauma committee chairman describes program aimed at establishing standards by which hospital service can be evaluated by local teams; surgeons and nurses also discuss recovery room problems and aims.**

New York.—A systematic method for evaluating hospital emergency room service is expected to result from a program described here last month by Dr. Preston A. Wade, professor of surgery at Cornell University Medical College.

Speaking at a sectional meeting of the American College of Surgeons, Dr. Wade said a pilot study to be conducted at the New York Hospital by the college's committee on trauma, of which he is chairman, will seek to establish standards which may be used by local trauma committee teams to evaluate hospital emergency service in their own communities.

The study is an outgrowth of a survey conducted last year by the New Jersey regional committee on trauma (see box on p. 68), Dr. Wade said. In the New York pilot study, he added, an attempt would be made to develop standards for staffing the emergency department and for emergency room space, facilities and equipment.

Such standards, Dr. Wade said, would distinguish between the needs for emergency facilities and services in different communities, and in hospitals of different types and sizes. Standards for a 500 bed hospital in a big city obviously would be useless for a 75 bed hospital in a small community, he pointed out.

Featuring a joint program for surgeons and nurses, the four-day meeting attracted a record crowd of 6000 physicians and nurses who took part in a busy program of clinics, hospital tours, lectures, panel discussions, and moving picture demonstrations.

One of the liveliest discussions of the meeting took place at a panel on organization and management of recovery wards, where Moderator Rob-

ert M. Zollinger, chairman of the department of surgery at Ohio State University College of Medicine, directed a barrage of questions from an interested audience to panel members representing surgery, nursing, anesthesiology and hospital administration. Surgery and nursing disagree on the basic question of jurisdiction of the recovery room, it developed at the outset. The recovery room is in the surgeon's domain and should be actively supervised by the operating room supervisor, said Dr. John M.

Beal, attending surgeon at the New York Hospital—a view that was vigorously contested by Mary A. Connolly, assistant director of nursing at Memorial Center for Cancer and Allied Diseases, New York, who pointed out that the recovery room is a nursing service and thus belongs in the jurisdiction of the nursing director. Both sides had some support from the audience, which also included a few who considered the recovery room as part of the anesthesiology department.

Wherever it is jurisdictionally, the

### American College of Surgeons Regents Table Resolution on Hospital Boards

NEW YORK.—At a meeting here last month, the board of regents of the American College of Surgeons tabled a resolution recommending that the college adopt a policy favoring the election of active medical staff members to voluntary hospital boards of trustees. The resolution had been approved last year by the board of governors of the college and referred to the board of regents for action.

Also tabled by the board of regents, policy-making body of the college, were companion resolutions recommending tenure for senior hospital staff members and suggesting that the college seek the views of other major specialty groups regarding staff representation on hospital boards.

The reason the regents didn't

take any action on the resolutions, a member of the college staff explained, was that they felt the college was concerned with professional and teaching standards in hospitals and did not need to formulate policies on the subjects of the resolutions.

Prior to the regents' meeting, the fact that the college board of governors had approved the resolution on hospital board membership for physicians was misinterpreted by some doctors and hospital administrators to mean this had become the policy of the college. The board of governors is a 174 member body that elects the 19 member board of regents, the only group empowered to act officially for the American College of Surgeons, it was explained. #

recovery room geographically should be situated as close as possible to the operating room, Dr. Beal insisted. The recovery ward should be on the same floor as the operating rooms if at all possible, Dr. Beal said. "But the most important thing is to have a recovery room," he added.

For information on the size and equipment of the recovery ward, the panel turned to its hospital administrator member, Tracy Storch, associate director of the New York Hospital. Studies indicate a minimum space requirement of 90 square feet per bed, Mr. Storch said. The number of re-

covery beds required in a hospital depends on the nature of its service, he pointed out. At the New York Hospital, with 800 active beds and 13 operating rooms, the recovery room includes 16 beds—a ratio that has worked out satisfactorily, he reported.

The New York Hospital charges a

## CHECK LISTS FOR HOSPITAL EMERGENCY ROOM SERVICE

**ENCOURAGED** by the success of check lists used by the New Jersey regional committee on trauma of the American College of Surgeons headed by Dr. Spencer T. Snedecor, Hackensack Hospital, the national trauma committee of the college will conduct pilot studies in a New York hospital aimed at developing a systematic method for evaluating hospital emergency room service. The New Jersey check lists:

### VOLUME OF WORK: TOTAL OF PATIENTS

1. Traumatic
2. Surgical
3. Medical
4. Miscellaneous

### ORGANIZATION OF TRAUMA SERVICE

1. Which service has responsibility for emergency room?
2. Team organization
  - a. How does it function?
  - b. When are attending staff members called?
  - c. Which service has charge of multiple injuries?
  - d. Who is captain of team?
  - e. Who calls consultations of different services?
3. Standard operating procedures
 

Each service; for example, eye, foreign bodies, E.N.T., nose bleeds, general surgery, abdominal trauma?
4. Standards of practice. Who has responsibility for supervision of doctors using emergency room?
  - a. General practitioners?
  - b. Compensation doctors?
  - c. Various specialists?
5. Provisions for special types of cases
  - a. Burns
  - b. Hands
  - c. Shock; availability of blood
  - d. Fractures—
    1. How are they handled?
    2. Who may reduce fractures?
    3. What fractures do interns reduce? Are they supervised?
    4. Are postoperative x-rays taken on all cases?
    5. What fractures are admitted?
    6. Who has supervision of fracture surgery?
    7. Who approves reductions?

### STAFF

1. Attending physicians
  - a. Services represented
  - b. Qualifications
  - c. Daily attending call list
  - d. Assignment of cases
  - e. Consultations
2. Interns—residents
  - a. Adequate assignment at all hours
  - b. Training—reliability and responsibility
  - c. Teaching—supervision, instruction guides

3. Nurses—R.N.'s
  - a. Adequate coverage at all hours
  - b. Proper supervision
  - c. Special training
4. Practical nurses—aides
5. Orderlies—training
6. Volunteers—first aiders
7. Extra help—all categories—when needed

### PHYSICAL FACILITIES

1. Reception area
2. Examination—treatment rooms
3. Screens in rooms
4. Minor operating rooms
5. Fracture—plaster room
6. Observation or overnight rooms
7. Waiting room for relatives
8. Storage space
9. Communication system
10. Scrubbing facilities
  - a. Doctors
  - b. Patients
11. Relation to:
  - a. X-ray
  - b. Pharmacy
  - c. Laboratory
  - d. Central supply

### EQUIPMENT

1. Stretchers: adequate number and type—hydraulic, adjustable for position
2. Wheel chairs
3. Operating tables
4. Lighting
5. Rest beds
6. Oxygen
7. Suction
8. Resuscitation
9. Defibrillator
10. Tracheotomy
11. Gastric lavage setup
12. Catheter setup
13. Instruments: selection and quality for different types of surgery
14. Types of sutures
15. Splints—slings
16. Bandages: muslin, elastic, adhesive
17. Linen for drapes, towels
18. Masks, caps, gowns
19. Incidental equipment basins, syringes
20. Burn packages
21. Intravenous fluids and equipment (dextrose, plasma, glucose, cut-down sets)
22. Medications
  - a. stimulants
  - b. antiseptics
  - c. biologicals

- d. antibiotics
- e. sedatives
- f. other drugs

### SPECIAL SERVICES

1. X-ray
  - a. Availability
  - b. Reading of emergency films
  - c. Night and week-end coverage
2. Laboratory
  - a. Availability for emergency tests
3. Anesthesia
  - a. General availability and quality for fractures
  - b. Local—Solutions used

Instruction of interns

### PROCESSING OF PATIENTS

1. Reception—technic
2. Information—registration
3. Charts—Are they written before patient leaves emergency room? (Special Emergency Traumatic Charts?)
4. Adequate treatment period in emergency room
  - a. Until shock is relieved
  - b. To O.R. when ready
  - c. Observation
5. Admission of patients
6. Routine workup
7. Fracture patients: proper splinting, handling, discharge instructions
8. Discharge of patients
  - a. Clearance by:
    1. Interns
    2. Attending staff
  - b. Instructions to patients
    1. Own doctor
    2. Staff doctor
    3. Clinic
    4. Pamphlet

### SPECIAL INSTRUCTIONS

1. D.O.A.
2. Alcoholics
3. Mental cases
4. Suicides

### CHARGES

1. What are the usual hospital charges? Are they adequate and responsible for good service?
2. Does hospital differentiate clearly between hospital service and surgical?
3. Are attending surgeons permitted to charge—what cases?
4. How are compensation cases assigned?

separate fee for recovery room service, Mr. Storch said. The fee varies from \$10 to \$25, depending on the amount of equipment and supplies used and the time the patient remains in the ward. When some resistance developed to a charge for the "recovery room," patients' bills were revised to show the charge for "recovery service" and the objections disappeared, Mr. Storch said.

If the recovery room is intended as a true postanesthetic or postoperative service, and not as an intensive care ward, the length of stay varies with the type of anesthetic, and the patient may be released to his nursing floor as soon as he has recovered from the effects of the anesthetic, the panel agreed. The decision to release the patient should be made by the surgeon in consultation with the anesthesiologist, it was indicated—probably in most cases with delegation of broad discretionary authority to the nurse in charge.

#### RECOVERY ROOM DOCTRINE

Other recovery room doctrine as laid down by members of the panel included:

1. Recovery rooms should be staffed by graduate rather than practical nurses, and even graduates require some special preparation for recovery room duty.

2. Drugs and other recovery room supplies should be instantly available and thus not stored in locked cabinets, with the single exception of narcotics, which need not be kept in the recovery room.

3. The need to keep the recovery room open 24 hours a day depends on the nature of the hospital's emergency service.

4. It is desirable where possible to make provision for families to visit critically ill patients in the recovery room; such patients may be isolated by screening if a separate room or cubicle is not available.

5. It is not necessary to separate the sexes in the recovery room; special facilities for child patients are desirable but not necessary.

6. Generally speaking, the recovery room staff should include one graduate nurse for each two beds, with at least one extra nurse available at all times.

7. Private duty nurses may be used in the recovery room, but while there they are definitely working under supervision of the nurse in charge.

Another panel discussion that threatened to outrun the clock examined the psychological needs of surgical patients. The discussion followed a lecture by Dr. Arthur M. Sutherland, chief of the neuropsychiatric service at Memorial Center, who told an audience of nearly 1000 nurses that sur-

gery for cancer frequently threatens the patient's basic patterns of adaptation and may leave deep-seated psychic scars. This is particularly true where the surgery affects the organs of elimination or reproduction, Dr. Sutherland pointed out. "If the defense of cleanliness and control is disrupted by removal of the sphincter," he said, "then condemnation is feared from the entire world—as it was once feared from the toilet-training mother. Similarly, if a woman feels her value and acceptability to others is mainly predicated on beauty and shapeliness, removal of the breast may seriously compromise her basis for relating to others."

Emotional disturbances following cancer surgery may be generally classified in six types, with some duplication and overlapping. The types are as follows:

1. Emotional and physical dependency, especially on the surgeon and nurse, shown by the patient who feels unable to function in his own defense or to fulfill his own needs.

2. Anxiety focused on possible recurrence of cancer and fears of unacceptability to other people, inability to perform work, or abolition of other activities.

3. Postoperative depressions—sometimes with severe agitation and suicidal tendencies.

4. Hypochondriacal reactions, frequently associated with inaccurate notions about the body and its functions.

5. Compulsive reactions, usually in patients having operations involving the rectal sphincter; compulsive practices are centered around irrigation of the colostomy.

6. Paranoid and delusional reactions by patients who feel that they have brought the disease on themselves and may project feelings of guilt onto others, such as the surgeon or nurse.

Often the emotional reaction to surgery involves members of the patient's family, Dr. Sutherland pointed out. Usually, the postoperative relationship is an extension of the family relationship that existed preoperatively, he said. "Where the relationship between spouses has been warm, the patient can expect continuing support and sympathy," he stated. "He can receive practical help and encouragement in the pretreatment phase, and after the operation or the treatment he can expect and can accept nursing care from the spouse when he returns home. Despite impairment of earning power, he can continue to be loved."

"A large group of marriages are essentially 'façade' marriages, with partners indifferent or ambivalent to one another and expecting little from each other. In this type of marriage

the patient can expect little help from the spouse, and the spouse usually is excluded or excludes himself from planning for treatment or for care."

The common concept of rehabilitation goals for the surgical patient may not apply in all cases, Dr. Sutherland warned. "The aim of most rehabilitation programs is to restore the patient to gainful or socially useful activity, and by this means help him to regain and maintain his self-respect," he pointed out. "It can be argued that the aim of rehabilitation as here stated is peculiarly an upper-class, white American, Protestant ideal, a so-called 'Yankee value.' Such an aim may not be meaningful for all other classes or ethnic groups. We may well miss the point of what constitutes a rehabilitated individual. The American of certain ethnic origin may not go back to work. He may be perfectly content to spend his time with his friends and his family and may see no value in returning to a hard, uninteresting and depleting job. Who likes to lay bricks? Clinic patients in a city like New York are rarely upper-class Yankees, and the imposition upon them of the standards of the upper-class Yankee group may be inappropriate."

#### PROBLEMS WITH ALL PATIENTS

Problems that Dr. Sutherland described with cancer patients may exist, though perhaps less intensively, with all surgical patients, a panel of nursing, psychology and psychiatric authorities agreed following the lecture. Whether she be student or graduate, the nurse herself is a part of the patient's psychological resources and can become a part of the patient's inner life, Dr. Morton Bard, clinical psychologist on the staff of Memorial Center, suggested.

"But it takes two to tango," he warned. "The nurse also receives and internalizes her patients. She also has conceptions and reactions to others and may have feelings of frustration and guilt."

In response to such feelings, nurses may withdraw and impersonalize their work, Dr. Bard said, thus protecting themselves from emotional upset but robbing their patients of needed emotional aid. He suggested group sessions for surgical nurses in which their feelings may be discussed and thus relieved.

Too many nurses feel they must present the appearance of strength and imperviousness at all times, Rena E. Boyle, consultant to the Division of Nursing Resources, U.S. Public Health Service, Washington, D.C., told the group. Young nurses, especially, should be permitted to cry sometimes to relieve their feelings and should not consider it an admission

of weakness to show emotion, it was suggested.

"The patient will get what you feel and act, not just what you say," Dr. Rollo May, New York psychoanalyst, declared.

A joint action program aimed at preventing accidents and improving care of accident victims was announced by the college, the National Safety Council, and the American Association for the Surgery of Trauma during the meeting.

As outlined by representatives of

the three participating organizations, the program will include:

1. Public education in accident prevention and handling of the injured.

2. Employment of joint state and local committees of the American College of Surgeons and National Safety Council, together with other interested surgeons, safety engineers, and public officials to formulate safety plans for local communities.

3. Possible registration of unusual cases of injury.

4. Proposed investigations of emergency care of traffic injuries.

5. Model legislation to require adequate training in first aid and transportation of the injured for ambulance attendants, policemen and firemen.

6. Cooperation in the production and improvement of training materials and instructional aids dealing with problems in handling the injured.

Educational activities in the program will include meetings to be conducted in conjunction with national, regional and local activities of the participating organizations, it was explained. In addition, courses of instruction in first aid and transportation of the injured will be developed, and available materials will be reviewed for the purpose of emphasizing surgical aspects of the problem.

Surgeons are especially concerned today about the care of patients with multiple injuries involving different parts of the body, Dr. I. S. Ravdin, chairman of the college board of regents, explained, because proper care of such patients may cross the lines of demarcation between the various medical and surgical specialties.

"Survival of these patients often depends directly on a coordinated, carefully planned regimen based on the concept that all treatment is a team problem and all who see or handle the patient are actually or potentially members of the team," Dr. Ravdin said. Improvement at every point in the approach to such multiple injury victims is a goal of the joint action program, he added.

Another aspect of the program, registration of unusual cases of trauma, has yet to be worked out and approved but, as proposed, would be conducted primarily by the surgical organizations, it was reported.

Physicians and hospitals would be asked to report unusual cases to the college, it was explained, and this information would then be evaluated and reported back to physicians by a special committee of the college and American Association for the Surgery of Trauma.

Resources of the three organizations will be used in the effort to advise and assist civic groups to obtain passage of local ordinances requiring adequate training in handling of the injured by ambulance attendants, policemen and firemen, the joint statement said.

Under a proposed model ordinance, ambulance attendants are required to have completed standard and advanced first-aid training and additional training as recommended by local health departments, to carry cards indicating their qualifications, and to be reexamined and certified annually for their fitness to serve. #

## Administrators and Trustees Must Understand Medical Problems and Needs, Institute Hears

PHILADELPHIA.—The administrator's responsibilities include operation of the hospital as an institution, administration of the income and expenditures necessary to provide proper care, and standards of professional service, Dr. Albert W. Snoke, director of Grace-New Haven Hospital, New Haven, Conn., said last month.

Dr. Snoke spoke before a trustee institute sponsored by the Hospital Council of Philadelphia at Franklin Institute.

"The administrator's responsibility for patient care is identical with that of the board of trustees. He is their representative and consultant.

"The administrator must understand the problems and medical needs of the institution and the staff, must arrange for hospital service to meet these needs, and must interpret the hospital's problems and requirements to the attending physicians or the medical staff," Dr. Snoke said.

### BOARD IS RESPONSIBLE

Dr. Kenneth B. Babcock told 300 trustees attending the institute that the governing board has a legal and moral responsibility for the conduct of the hospital. It is responsible to the patient, the community, and sponsoring organizations, he said, and its official representative is the hospital administrator.

"A medical staff is responsible to the patient and to the governing body of the hospital for the quality of all medical care rendered to patients in the hospital, and for the ethical and professional practices of its members," he continued.

John T. Ryan Jr., president of the Hospital Council of Western Pennsylvania, called the suitable replacement of obsolete buildings "one of the most pressing problems of today," in some

respects more important than actual expansion of bed facilities.

The speakers and others participated in a panel discussion, moderated by Raymond P. Sloan, chairman of the editorial board of *The Modern Hospital*. Among the answers to questions from the trustees were the following:

1. The accreditation program directly involves trustees, inasmuch as they are responsible for the appointment of the attending medical staff which supervises medical care in a hospital.

2. The accreditation program does not concern itself with financial policies or procedures.

### HAVE BROAD REPRESENTATION

3. Accreditation standards do not prescribe the composition of a hospital board. Boards of accredited hospitals should include broad representation of responsible groups in the general community. This may include members of the active medical staff.

4. There is no reason a hospital administrator should hold an M.D. degree. A properly trained and qualified nonphysician is a professional man in his work as a hospital administrator.

5. Trustees may sometimes be justified in making or withdrawing a staff appointment against the recommendation of the active medical staff. The board is the final authority.

6. Trustee responsibility for patient care can be expressed without interference with medical judgment and procedure. This is accomplished by intelligent and thoughtful selection of members of the attending staff.

7. As a general rule, board members should not "do business" with a hospital which they serve as trustees. There may be special circumstances where this rule would not apply. #

**The readily expandable service facilities in this vertical hospital, built around a center core, will eventually handle five more floors and a new wing**



Mount Sinai Hospital in Los Angeles contains some 250 beds, about half for indigent patients. Built on a 3 acre site, the vertical plan was used to save space. Another view is in color on this month's cover.

## **Mount Sinai Let the Work Load Determine New Building's Design**

**T**HE approach to the design of the new Mount Sinai Hospital in Los Angeles was first to determine the work to be accomplished by the hospital and the methods and procedures necessary to accomplish it as efficiently as possible, and then to design a building that would achieve the desired results, according to architects and hospital officials.

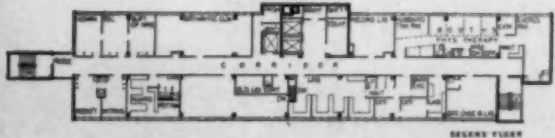
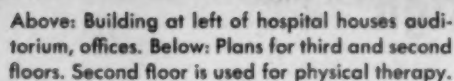
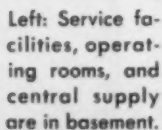
The first unit of the hospital, shown in color on this month's cover and in the plans and photographs on the following pages, is an eight-story reinforced concrete structure containing 252 beds. Future additions will bring the bed complement to 452. The building is so constructed that another five stories can be added and, although the present service facilities are not adequate to handle the additional beds, the architects explain that they are readily expandable.

Because Mount Sinai Hospital has a special interest in the care and rehabilitation of chronically ill patients, facilities for rehabilitation and recreation are unusually comprehensive. This section is under the direction of a physician. Space is provided for consultation and examining rooms and even private exercise rooms for patients who need special help. Other features designed for the comfort and pleasure of the chronically ill are the occupational therapy department, and the barber and beauty shops.

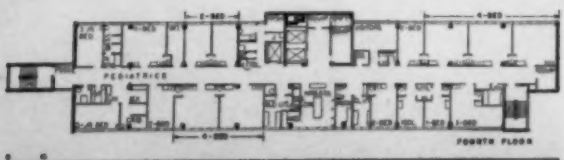
Experience with the hospital since its opening indicates that the functional approach has resulted in a building that functions with great efficiency.

(For plans and photographs, see following pages)

**The Modern  
Hospital of  
The Month**



**Below: Plans for fifth and fourth floors. Pediatric patients have special section on fourth floor.**



## OPEN COLONNADE AND

**T**HE first unit of Mount Sinai Hospital was designed by Welton Becket and Associates, Los Angeles, architects and engineers associated with Palmer, Krisel and Lindsay, architects.

The 3½-acre site on which the hospital is located was donated by the Levine Foundation. The initial element is eight stories, but the design allows an additional five stories to be added in the future. The structure's design is contemporary and is of reinforced concrete. The exterior finish is multicolored lacquer.

Among the unique design features of the hospital is a "jack-knife" stairway at the north end of the building.

The building plan has two eight-story wings extending from a central windowless shaft. The ground level of the north wing is an open colonnade, thus providing a covered walkway and a circular driveway allowing patients to step from their cars into the hospital lobby. The colonnade also tends to give the building an interesting "suspended" effect.

When fully completed the main structure will contain 452 beds, an outpatient department, a nurses' training school, and service building. One-half the total beds in the hospital will be free to the indigent sick of all races, creeds and colors.

The basement contains air conditioned radiology, surgery, recovery, kitchen and laundry units as well as mechanical and storage facilities. The main lobby, a waiting room, a coffee shop, pharmacy, business office, cafeteria, gift shop, emergency room, and dining areas are located on the first floor. Pathology, routine laboratory, physical therapy, interns' and nurses' quarters, and administrative offices occupy the second floor. Beds for acute and chronically ill patients are on the third to eighth floors. Each of these floors contains approximately 40 beds.

The patients' rooms have color combinations and furnishings designed to reflect more of a home bedroom atmosphere than the usual "sanitary white" of a hospital.

Each patient's room has a two-way audio communication system connected with the central nurses' station.

The hospital is completely air conditioned. Special screens are sandwiched between glass panes to reduce sun glare and solar heat load.

A three-story contemporary design auditorium building is located to the east of the main block. This structure contains administrative and fund raising offices and the auditorium has removable seating, allowing for a wide variety of social and charitable activities.

The third phase of the Mount Sinai Hospital building program will be the addition of a six-story wing running west from the central core of the principal structure, forming the leg of the "T"-shaped completed project.

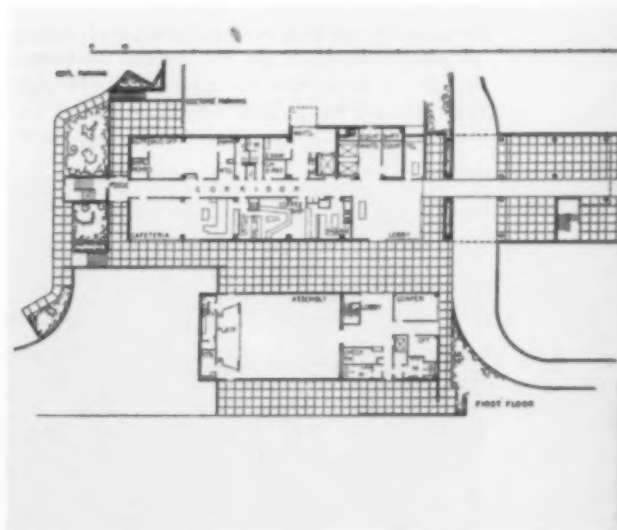
Maynard Woodward was design director of the hospital; Harry Widman was medical planning director; Philip Kimmelman served as project chief, and Richard Bradshaw was structural engineer. Hospital consultant was Walter J. Mezger, now hospital administrator.

## JACK-KNIFE STAIRCASE ARE UNIQUE DESIGN FEATURES OF MOUNT SINAI

The hospital presented here has been selected as The Modern Hospital of the Month by a committee of editors. Award certificates have been presented to the hospital, the architects, and state officials. A similar award will be made each month.

### Outline of Construction Costs

Total project cost.....	\$2,880,332.00
No. of beds.....	252
(expandible to 452)	
Cost per bed.....	11,400.00
Total square feet.....	114,965
Square feet per bed.....	455
Cost per square foot.....	25.06
Total cubic feet.....	1,426,150
Cubic feet per bed.....	5,660
Cost per cubic foot.....	2.02



Above: First floor plan shows how driveway is connected to hospital, so that patients can step from a car into hospital. Besides auditorium, fund raising offices will be located in three-story building at bottom of plan. Left: Lobby of Mount Sinai Hospital. Waiting room is just beyond. Below, left: Nursing station is placed in center of each floor. Elevators are opposite, services are near by to save nurses' time, provide maximum control. A floor secretary sits at front of each station to screen telephone calls initiated by patients, handle inquiries regarding patients' conditions. She also routes orders for laboratory, pharmacy and x-ray services through the pneumatic tube system. Dumb-waiter adjacent connects with central supply, central pharmacy, and laboratory. Floor secretary's job is filled from 8 a.m. until 10 p.m. every day.

(Continued on Page 74)

Right: Central supply and sterilizing room is located in hospital basement and staffed 24 hours each day. Operating suite and recovery room also are in the basement. Location of surgery has worked well, since vertical travel of supplies has been eliminated.



Below, center: A private room at Mount Sinai Hospital, showing lounge provided for relatives of patient. Color combinations, furnishings are planned to reflect atmosphere of home bedroom, rather than stark hospital room. The hospital is air-conditioned.

Bottom of page: In a two-bed room, beds are arranged against opposite walls. Control box extending on rod at bedside contains switches for lights and radio and button to operate the voice intercommunication system. Each bed has oxygen outlet.

## CENTRALLY LOCATED NURSES' STATIONS FEATURE FLOOR SECRETARIES



THE functional design of the building was developed to accommodate predetermined traffic flows and work procedures.

Each floor houses approximately 40 beds and the nurses' station is placed in the exact center with utility rooms, diet kitchen, visitors' room, linen chute, bathrooms and so on clustered about this point. A service elevator and two passenger elevators are also located at this central point opposite the nurses' station.

The nonnursing activities revolve about a floor secretary stationed at the front of the nurses' station. This job is staffed from 8 a.m. to 10 p.m. The secretary screens all calls initiated by patients on a voice intercom system, which conserves the nurses' time. She handles inquiries regarding a patient's condition and can give reliable information, because she is in close touch with the 40 patients on her floor. She handles orders on the laboratory, pharmacy and x-ray, using key sorting system cards and slips. She sends these orders through a pneumatic tube system so that they reach their destination without delay. Available to her is a dumb-waiter which connects directly with the central pharmacy, central laboratory, and central supply and sterilizing room. Charting desks are custom designed and provide storage space above for various printed forms. The usual oxygen system is provided with each bed having an outlet piped from a central manifold.

The operating suite is located below ground level and contains four major surgeries, a fracture room, and

## OPERATING SUITE AND ADJUNCT SERVICES ARE BELOW GROUND LEVEL

a cystoscopy room. The four major rooms are located within a tight circle and everything normally needed while they are in use is available within this circle, i.e. sterile packs, sterile water, a high speed autoclave, and the scrub-up sinks.

The suite also contains a recovery room where postsurgery patients are held under close observation until they have fully reacted. They are then moved to the nursing divisions.

The central supply and sterilizing room is adjacent to surgery and is planned to perform most of the work

ing divisions, but the nursing department is responsible for distribution to the patients.

A cafeteria and a coffee shop are located on the first floor. To expedite service to and from these facilities a floor leveling dumb-waiter accommodating a cart has been installed.

The business office is located on the first floor with the admitting office adjacent to it. During off-hours one person can cover both offices. Admissions are expedited by the use of pre-admission forms which are distributed to the doctor's office and, with his

age stay of the patient in this section may be as much as 60 days. For that reason an occupational therapy department, a barber shop, and a beauty shop have been provided.

The voice intercommunication system between patients and nurse is a definite improvement over the conventional nurses' call system. However, it requires constant training education and insistence that it be fully utilized to get all possible benefit from its use.

The "straight-away" corridors with a central control point are conducive



Kitchen, located in basement, is divided by wall into areas for food preparation and tray assembly. Dietary staff delivers food to floors; nursing department is responsible for distribution to rooms. Layout of kitchen was geared to meal cart system of service.



Mount Sinai at night. Colonnade, providing covered walkway and driveway, gives building a "suspended" effect. Hospital is planned for expansion to 452 beds. The third floor houses chronic cases.

for surgery as well as for the nursing divisions.

All the modern labor saving equipment, such as a syringe washer, needle washer, glove conditioner, and automatic washing machine, is provided. Work load and staffing are arranged for a 24 hour continuous operation.

The kitchen is also located below ground level. It is actually divided into two parts by a wall. The food preparation area is in one part and tray assembly in the other. The meal cart system of food distribution was selected and the layout of the kitchen geared to it. The design was predicated on buying prefabricated meats, "ready for the pot," and on using frozen fruits, vegetables and other frozen foodstuffs as much as possible.

The dietary department is responsible for delivering the food to the nurs-

cooperation, executed by the patient and sent to the hospital in advance of the patient's admission. A metal address plate is prepared for each patient and sent to the nursing division where he is located. This plate is subsequently used for imprinting all record forms, orders, charges and so forth.

All the usual ancillary services—pharmacy, x-ray, laboratory—are provided.

The absence of a maternity division should be noted. This service was omitted because a survey confirmed the information that sufficient maternity beds were available in the community. It should be noted also that the third floor has been planned for the care of chronic disease patients who may be rehabilitated by intensive nursing and medical care. The aver-

to good control and efficient operation.

The pneumatic tube system is an efficient and most valuable tool and labor saving device in providing care for the patient.

Making all nurses' stations identical and locating them in similar positions is helpful in standardizing procedures and in training personnel.

The fact that a dumb-waiter opens directly into the nurses' station and connects directly with all major ancillary services is a labor saving and timesaving convenience.

The location of surgery below ground level has worked out well. It eliminates the vertical travel of supplies. The lack of daylight has occasioned no unfavorable comments from doctors or personnel constantly working in the area. #

## ABOUT PEOPLE

### Administrators

**Glen W. Fausey**, director of Edward W. Sparrow Hospital, Lansing, Mich., for 19 years, has resigned. Before going to Lansing in 1939, Mr. Fausey held various positions at other Michigan hospitals, including a two-year term as superintendent of Pontiac General Hospital, Pontiac. He is a former trustee of the Michigan Hospital Association, and a member of the American College of Hospital Administrators. **Donald H. Pound**, a former member of the hospital staff, has been named acting director. He currently is on the faculty at Michigan State University.



Glen W. Fausey

**Henry X. Jackson** has been appointed administrator of Valley Presbyterian Hospital, Van Nuys, Calif. Mr. Jackson presently is administrator of Knox County General Hospital, Rockland, Maine. He also has served as administrator of Marin General Hospital, San Rafael, Calif., and as assistant administrator of Herrick Memorial Hospital, Berkeley, Calif. Mr. Jackson is a graduate of Northwestern University's hospital administration program and a fellow of the American College of Hospital Administrators.



Henry X. Jackson

**Richard A. Yarmain** has been appointed assistant director of Newport Hospital, Newport, R.I. Mr. Yarmain, who studied in the hospital administration course at Washington University, took his administrative residency at University Hospital, Ann Arbor, Mich.

**Walter J. Thomas** recently was named assistant administrator of Latrobe Hospital, Latrobe, Pa. He joined the hospital staff in 1956 as credit manager and director of admissions.

**Ernest L. Bliss** has been appointed administrator of the Mather Home, Evanston, Ill. Mr. Bliss, a graduate of the course in hospital administration at the University of Chicago, formerly was administrator of Jackson-Madison County General Hospital, Jackson, Tenn.

**William E. Claypool**, associate administrator of University Hospital, Columbus, Ohio, for nearly 10 years, has been appointed administrator of West Allis Memorial Hospital, West Allis, Wis., effective May 1. Construction of the 254 bed hospital is scheduled to begin in August. Mr. Claypool is a graduate of the hospital administration course at Washington University.

**Edith Wilcox**, administrator of Lutheran Community Hospital, Norfolk, Neb., for more than 10 years, has resigned. She plans to resume hospital work after taking a vacation. Mrs. Wilcox is a trustee of the Blue Cross plan in Nebraska, and a former trustee of the Nebraska Hospital Association.

**Robert J. Lawrence** has been appointed to the newly created position of assistant administrator at Milwaukee Children's Hospital, Milwaukee. Previously, Mr. Lawrence was director of plant services at Muhlenberg Hospital, Plainfield, N.J.



Robert J. Lawrence

**James F. Haile**, manager of the Veterans Administration hospital at Minot, N.D., has been named manager of the V.A. center at Kecoughtan, Va. **Elvan P. Whitaker**, assistant manager of the V.A. hospital at Denver, has been appointed manager of the Minot hospital to succeed Mr. Haile. **Reuben Cohen**, former manager of the Kecoughtan center, has been named manager of the V.A. hospital at Sunmount, N.Y.

**Donald F. Zuercher** has been appointed administrative assistant at Chippewa County War Memorial Hospital, Sault Ste. Marie, Mich. Mr. Zuercher, who is a graduate of the hospital administration program at the University of Minnesota, was previously research associate in the hospital administration course at the University of Michigan.



Donald F. Zuercher

**Mabel DeSanctis** has been appointed acting administrator of Skin and Cancer Hospital of Philadelphia, succeeding **Frank C. Seaman**.

**Shirley Lindberg, R.N.**, administrator of Marion Memorial Hospital, Marion, Ill., has resigned to become coordinator of the educational program of the Illinois Hospital Association. Mrs. Lindberg, who has been associated with the Marion hospital since 1952, has held various other hospital administrative posts. She is a graduate of Evangelical Deaconess Hospital School of Nursing, Milwaukee, and a member of the American College of Hospital Administrators. **Norman D. Harding**, assistant administrator and head of the clinical laboratory, will succeed Mrs. Lindberg.



Shirley Lindberg, R.N.

**Ernest C. Nott Jr.**, director of personnel and public relations at Baptist Memorial Hospital, Jacksonville, Fla., has been appointed administrative assistant at North Broward General Hospital, Fort Lauderdale, Fla.

**S. Earl Grimes Jr.** has resigned as administrator of King's Daughters' Hospital, Brookhaven, Miss., to become administrator of New Biloxi Hospital, Inc., Biloxi, Miss., succeeding **Emma Lou Ford, R.N.** Mr. Grimes, who has been at King's Daughters' Hospital since 1949, will be succeeded by **T. W. Crowley**, business manager of Mississippi State Hospital, Whitfield.

**Sister Mary Elizabeth** has been named administrator of De Paul Hospital, Norfolk, Va. She formerly was administrator of Providence Hospital, Detroit. She succeeds **Sister Rosanna**, who has joined the staff of Sisters' Hospital, Waterville, Maine.

**Parker Morton**, assistant administrator of Cape Fear Valley Hospital, Fayetteville, N.C., has been named administrator of Eastern North Carolina Baptist Hospital, New Bern, N.C.

**Truman Yates**, assistant administrator of Good Samaritan Hospital, Phoenix, Ariz., has been named administrator of the new hospital at Yuma, Ariz., which is scheduled to open this month.

**Orville L. Ferrell**, assistant administrator of Rowan Hospital, Salisbury, N.C., has resigned to become administrator of Cherokee County Memorial Hospital, Gaffney, S.C.

(Continued on Page 138)

*By developing better understanding and  
more cooperative relationships between  
the board of trustees and the medical staff*



## Hospitals can help improve medical care

ALBERT W. SNOKE, M.D.

THE hospital of the future, through its educational activities and opportunities, and through its physical and technical facilities, will have great influence upon the quality of medical care. However, its most important contribution has been and will continue to be the control and improvement of medical care, not by fiat or direction of the hospital administrator or the hospital board of trustees, but by providing a mechanism by which doctors can set and maintain standards of patient care that they are presently unable to do without the organized agency of the hospital.

May I digress for a moment and discuss what I mean by the "hospital"? I am not concerned with the bricks and mortar, or with that actual business corporation which permits the hospital to have legal existence. Although we may personify the hospital as being able to do this or that, we are actually referring to that complex of individuals including the board, the administrator, the medical staff, and the hospital employees who combine under a formal legal framework to constitute a living organization with a personality and an influence far greater than can be expected from a legally constituted business organization.

A hospital cannot successfully carry out its total responsibilities as a social institution unless all those associated with it understand their responsibility and that of their partners and thus work together as a harmonious whole. The most important responsibility of the hospital is the provision of good

medical care to the patients and this is a direct responsibility of the various individuals making up the hospital.

Hospitals are presently playing an important rôle in the control of the quality of medical care. Hospitals and physicians in general have high standards for the type of medical care that should exist in hospitals. However, neither hospitals nor physicians are universally doing as satisfactory a job as they should today, or as they will in the future, in using the hospital to meet these high standards. This is due in part to a lack of adequate understanding on the part of many doctors, hospital administrators, and boards of trustees of the potentialities that exist for control of the quality of medical care in a hospital. And many still do not understand how best to organize the hospital and its staff so as to achieve the common objective of improved patient care.

### TRUSTEES ARE RESPONSIBLE

The fundamental and ultimate body upon which the quality of medical care in the hospital depends is the board of trustees of that institution. This is the body that is responsible to the community—both legally and morally—for everything that goes on in the hospital. These activities include maintenance, food and house-keeping, as well as public relations and finances. These activities also include the standards and the quality of the medical care that exist in the institution. It would appear to be self-evident that the board of trustees is vitally concerned over the medical care in the hospital. Frankly, it is difficult to understand how any self-respecting individual could become a member of a governing board of an institution concerned with patient care if his authority was not commensurate with his interest and responsibility.

I am emphasizing this point because the whole organization of the hospital and its control of standards of medical care are based upon the ultimate authority of the board of trustees of the hospital. It naturally follows that if a board is responsible for the medical care carried out in the hospital, it is concerned with the specific individuals—the doctors—who are practicing medicine in the hospital. This concern includes the doctor's professional ability, his character, and his responsibility to the hospital. This is the justification for boards of trustees having the final authority for appointing doctors to the medical staffs of their hospitals. It also emphasizes the fact that a hospital staff appointment is a privilege to be conferred by the hospital board to the individual physician—not a right to be expected or demanded by the physician merely by virtue of his having an M.D. degree and a state license.

It should be quite clear that no board of trustees, no matter how constituted, is in a position by itself to judge properly the caliber and quality of medical care in the hospital. If the board is to carry out its responsibility to the community, the board members must recognize that:

1. This is a highly technical subject over which they have no personal competence.
2. They must delegate this responsibility to the experts who can judge proper medical care.
3. They must give proper authority to those to whom they assign this responsibility.
4. They must develop proper communications from those individuals to whom they assign the responsibility and authority to the medical staff as a whole and to the board as a whole.
5. They must establish a logical

Condensed from a paper presented at the joint session of the American Public Health Association and the American Association of Hospital Consultants, Cleveland, November 1957. This paper is also being presented in the April issue of the American Journal of Public Health.

Dr. Snoke is director, Grace-New Haven Hospital, New Haven, Conn.

and simple organization so that these objectives can be obtained.

Such a program requires that the board appoint competent qualified physicians as chiefs of staff, chiefs of services, or of specific departments and assign to them the responsibility of seeing that proper medical practices are maintained in the hospital. These individual physicians now become changed in their relationship to the rest of the medical staff. They are no longer merely friends and associates of their colleagues with no influence or power other than moral suasion if they disagree with their medical practices or conduct. Their primary responsibility is not that of being a representative of the medical staff. They are now individuals with specific powers and responsibilities which come directly from the board of directors of the hospital through delegation of responsibility and authority. They are representatives of the board of trustees.

Contrast these same medical and surgical chiefs in the hospital with themselves as individuals in a county or state medical society. A licensed physician is legally entitled to do surgery of the most complicated nature. If he is incompetent, bungling or careless, his colleagues in the medical society can regard him with disapproval and advise or request him to change his tactics but they have no real power to limit him at all. However, these same colleagues when upheld by the designated authority from the hospital governing board can refuse surgical privileges to this individual completely, can restrict or control him—all through mechanisms developed by the hospital medical staff and the board and with the board's full knowledge and support.

The relationship of the chiefs of service in the hospital to the rest of the medical staff also becomes clarified when one analyzes their responsibilities and authorities. The chief of surgery, for example, is not only a senior surgeon who is respected by his colleagues and who is a highly competent consultant, he is also an administrative department head of the hospital, and as such has direct responsibility through the administrator to the board of trustees. The chief of surgery thus functions as a department head for the clinical activities of his service, and this involves administrative functions of discipline, appointments, development of policies and procedures affecting hospital operation in his area, and dealing with hospital personnel associated with his clinical divisions. This is in addition to his clinical review of his colleagues' activities and here again his function is administrative.

The administrative function and responsibility of the clinical chief has not been appreciated by administrators, boards or medical staffs to the extent that it should—or there would not be so much confusion concerning the method of appointment of these chiefs. The selection of the chief of a service should not be a popularity contest, nor merely the selection of an individual who is the most skilled technician. Qualities of leadership, administrative ability, judicial approach to problems, and personal responsibility are as important as clinical ability or seniority.

If the board is to have confidence that the responsibility and authority that it is delegating to the medical chief is properly placed, there must be a dependable method by which the administrative leader is selected. Simple voting by the medical staff carries no more guarantee of administrative ability than obtains in our state legislatures or in Congress.

#### HOW TO SELECT MEDICAL CHIEFS

It is much more logical that the medical chiefs be selected by judicial review of all appropriate staff members and, after careful consultation with the medical staff, the final appointments be made by the board. Those individuals selected as clinical chiefs should make up the executive committee or medical board that is administratively responsible to the board of trustees for all the medical activities in the hospital. Additional members of the medical board can quite properly be added upon direct vote of the medical staff—not only to make the medical board as representative as possible, but also to ensure direct representation of the medical staff. The basic medical board, however, that is responsible to the board of trustees for medical care in the hospital should be an appointed group.

It should be recognized that there are many difficulties in the development of an understanding and co-operative relationship between the board of trustees, the hospital administrator, and the medical staff. Some of the difficulties may be due to personalities, but often the fault lies in the actual organization and relationship of the board and the staff.

The board of trustees of the typical community hospital should be representative of the community and should be able to function judiciously and intelligently. This requires education, direction, experience, organization and communication. The type of individuals who make up the board will vary from one community to another dependent upon local situations, but, with few exceptions, the majority are laymen.

This immediately poses another problem that is debated endlessly: whether physicians should be on the boards of trustees of a hospital and in what proportion. The answer usually can be obtained in a given situation if one accepts the basic premise that the board of the hospital should be organized and administered in the manner that will provide the best patient care to all the patients and not special privileges to any few individuals, whether they be laymen or doctors. Experience in many hospitals has shown that a joint conference committee between the board of trustees and the administrator and the medical staff preserves all of the advantages of having doctors on the board, makes a much more efficient organization for developing mutual understanding, and eliminates the difficulties that potentially exist when a few doctors are placed in the anomalous position of being responsible to themselves.

I have suggested that the major rôle that hospitals will play in medical care in the future will be by providing an organized agency and a corporate mechanism by which doctors can set, maintain and enforce standards of medical care that they would be unable to do as individuals. Continued progress in this direction will be dependent upon proper organization of the board and medical staff so that competent physicians can assume administrative responsibilities. Of fundamental importance is the understanding of these medical chiefs that their first responsibility is to the patient in the hospital and to the board of trustees; secondarily to the medical staff as a whole.

It is my belief that hospitals will increase and extend this control over medical practice in the future as more physicians and board members realize the unique opportunity afforded by the hospital to enable physicians to improve patient care. One of the best examples of this is the increasing acceptance of the program of hospital accreditation by the Joint Commission on Accreditation of Hospitals. As physicians have understood the assistance toward improvement of patient care made available through the accreditation program and hospital organization, resistance has dropped and enthusiastic support has been received. As a result, medical staffs in hospitals throughout the country now are utilizing the hospital organization and the hospital authority to meet the accreditation standards. This gives a firm foundation from which the hospitals of the future can build as fine an edifice in qualitative care as they currently are building in bricks and mortar. #

The spacious Boston office of Dr. Dean A. Clark, general director of the Massachusetts General Hospital, is decorated with a picture and an example of the handwriting of every director of the hospital (except two) since 1821.

*Some facts on the executive suite, its location, size and furnishings, are gleaned from the results of a recent study by The Modern Hospital*



## How does your private office rate?

SHEPARD D. ROBINSON

**A**NNOYED, Proto T. Ype, hospital administrator, eased his bulk into the chair behind the desk in his 15 by 20 foot private office and flipped open his calendar diary.

With a frown, he noted his forthcoming appointment with a salesman for the Tri-City Grass Seed Company. Reaching into his personal filing cabinet, he thought to himself, "I'll tell that young man a thing or two about grass seed that doesn't come up."

Not finding the file on grass seed, Ype flipped the button on his intercommunication box and asked his secretary, who worked in an adjoining office, to bring it to him.

After studying it for a bit, he found his eyes wandering past his personal telephone number book to the framed reproduction of the "Stag at Bay" that hung on the painted plaster wall across from him, then to the familiar colored picture of Mount Whitney he had had enlarged from a photograph he had taken on his vacation three years ago, and finally to his membership certificate in Rotary International, which reminded him that he really should have passed up the chocolate sauce at lunch.

He had just picked up the speaker of his dictating machine to record a passing thought when he heard a car door slam outside the building.

Adjusting the venetian blinds, he saw the luckless seed salesman walking toward the entrance of the non-profit hospital.

Ducking between his desk and one of the two easy chairs in front of it in his rush to the door, Ype barked his shin on the side of one of the three straight chairs that had been drawn up during a staff conference that morning.

Angrily pushing the offending chair across the tile floor ahead of him, he limped for the door.

Poor Proto T. Ype's unhappy interlude during an otherwise uneventful day is perhaps a caricature of the average hospital administrator. But the details of his office and its furnishings are a synthesis of items which were reported in more than 40 per cent of the administrators' offices surveyed recently by *THE MODERN HOSPITAL*.

The survey, answered by 138 administrators in hospitals of all sizes from all over the United States and

Canada, produced results that lend credence to these generalities:

The predominant size for the administrator's office is 15 by 20 feet or smaller.

Ninety per cent of the administrators have a private office. This private office for the most part adjoins a secretary's office.

Of the 10 per cent who do not have a private office, about half share an office with a secretary or an assistant, and half find a desk in the general business office sufficient for their needs. All those who do not have a private office administer hospitals of 50 beds or less, 40 per cent of them coming from the mountain states.

Few hospitals, less than 10 per cent, afford their administrator a view of the surrounding countryside from his office window. Sixty per cent of those fortunate enough to claim such a view administer hospitals located in eastern seaboard states.

Five administrators, or 4 per cent, all from the West, must depend on TV horse operas for all their western scenery—they hold forth from windowless, interior chambers.

The commonest accouterment on

the administrator's desk is a booklet alphabetically listing frequently called telephone numbers.

Fortunate indeed are the administrators, only 13 per cent, who can invite their visitors to sit on a sofa. One-third of these lucky souls direct the affairs of hospitals of more than 600 beds and 50 per cent hail from eastern states.

Draperies and venetian blinds, or a combination of these window decorations, are by far the commonest window hangings in administrators' offices.

Paneled walls are another rarity in hospital administrators' offices; indeed, the administrator who can boast a view, a sofa and paneled walls can count himself among the most fortunate of men. The MODERN HOSPITAL survey revealed not one administrator so blessed, though a Floridian reported with obvious pride that his office overlooks a lake and is paneled. There seems to be no relationship between the existence of paneled walls and the size of the hospital or its geographic location. By far the majority of administrative office walls are painted plaster.

Those anticipating a visit to hospitals can expect to find the administrator's office floored with tile. This is the case in nearly 70 per cent of the hospitals.

Women doing business with hospital administrators will be heartened to learn that the cuspidor as a feature of the executive office is as nearly extinct as the \$1 per hour nurse, if the honesty of our correspondents is assumed. Only one administrator admitted to possessing one and he spoke

lovingly but defensively of it, somewhat as the man who by choice signs machine tabulated statements with a quill pen.

By far the commonest nonbusiness furnishing of the administrator's office is a membership certificate of some description. Surprisingly few administrators conduct their affairs within view of portraits of former administrators or hospital benefactors, though those who do are more likely to be troubled by the gimlet gaze of benefactors rather than predecessors.

In addition to the striking offices illustrated in this article, these descriptions of individual offices will pique the reader's imagination:

Unwelcome visitors don't stand a chance in the office described by one respondent. Large and five-sided in shape, it has two doors, one opening onto the lobby and the other onto the parking lot.

2. The privacy or lack of it. If the office is private, what is adjoining, and, if not private, who shares the office and where are private conversations conducted?

3. The view from the office window.

4. The furnishings, including business aids, furniture, windows, walls, floors and personal and esthetic furnishings.

The results were tabulated for totals and for variations involving geographic area and size.

Eighty-one per cent of the administrators surveyed said their offices are 15 by 20 feet or smaller. Twenty-four per cent are 10 by 15 feet; 10 per cent are 10 by 20 feet; 40 per cent are 15 by 20; 10 per cent, 20 by 20; 7 per cent are smaller than any of these, and 6 per cent are larger than any of these.

The private office enjoyed by 90 per cent of the respondents is ad-



Administrator Clyde W. Fox sits at his desk at the Washoe Medical Center, Reno, Nev. Hanging on the paneled wall behind him are, left to right: an appointment to the State Licensing Board, a Georgia O'Keeffe water color, an A.C.H.A. membership certificate, and an etching by the late Lionel Barrymore.



A water color reproduction hangs in the office of Emery K. Zimmerman of Elkhart General at Elkhart, Ind.

One administrator boasts an adjustable lounge chair, which many will hold should be standard equipment.

An intriguing picture comes to mind from the description of a U-shaped desk which is a feature of one other office. It is large enough to embrace a three-drawer filing cabinet and a bookcase.

Finally, there is the medical center administrator who has hung a 40 by 40 inch photograph of his section of the city on the wall of his office to aid in directing visitors to various elements in his plant.

Four major aspects of the administrator's office were considered in the survey. They include:

1. The size of the office.

joined by a secretary's office in 60 per cent of these cases, an assistant's office in 20 per cent, the business office in 25 per cent, and a waiting room in 9 per cent of the instances reported. Several respondents said board rooms adjoin their private offices.

Where the administrator's office is not private, those surveyed said it is shared with a secretary by 50 per cent of the administrators, an assistant by 36 per cent, the admissions office by 14 per cent, the records office by 21 per cent, and the general business office by 43 per cent. Seventy per cent of those who indicated they have no private offices said they conduct private and confidential conversations in the nearest available

room at the time such a conversation is requested.

Sixty-nine per cent of the administrators replying said their office window overlooks the hospital grounds, 16 per cent said they overlook the immediate neighborhood, 8 per cent can see an interior court, 18 per cent view a city street, and 8 per cent overlook the surrounding countryside. Many administrators, naturally, view a combination of these.

Following a device for listing often-called telephone numbers, an appurtenance of the desk of 89 per cent of those queried, a calendar diary and a filing cabinet are the next most popular business aids of the hospital administrators surveyed. Both of the latter are to be found in 80 per cent of the offices reported. A dictating machine is used in 36 per cent of such offices, a switchboard arrangement in 23 per cent, an intercom-

blinds, and 16 per cent said they have window shades.

Eighty-six per cent said their wall covering is painted plaster, 8 per cent said it is wallpaper, and 6 per cent said it is paneled.

Tile floors were reported in 67 per cent of the offices surveyed, 11 per cent are carpeted, 6 per cent have rugs, and 16 per cent other types or combinations.

Personal or esthetic furnishings to be observed in administrators' offices surveyed, in addition to membership certificates mentioned by 60 per cent of the respondents, include: original paintings, reported by 15 per cent of those answering the questionnaire; reproduced paintings, reported by 38 per cent; framed photographs, 38 per cent; portraits of predecessors, 2 per cent; portraits of benefactors, 3 per cent; calendars, 22 per cent; awards or citations, 34 per cent; pic-

A combination desk and conference table is used by Administrator Oliver G. Pratt at Rhode Island Hospital, Providence, R.I. Note the handsome paneled cupboard with matching doors behind the administrator's desk.



The office of Bolton Boone, administrator of Methodist Hospital, Dallas, Tex. adjoins an unusually comfortable conference room which can be closed off by the sliding doors shown. Planters are a relatively common decoration.



The drapery-venetian blind combination shown above in the office of Sister Marie Victoria, administrator of Memorial Hospital, Chattanooga, Tenn., is often seen in hospitals, according to the results of the questionnaire.

munications system in 43 per cent, and an adding machine in 23 per cent.

A lonely desk is the most common item of furniture found in the offices surveyed, reported by 43 per cent of the administrators. A desk and a worktable combination is used by 34 per cent of the executives and a desk and conference table combination by 23 per cent for a total of 100 per cent, leaving no room for the advocate of informality who operates without a desk at all. The accumulated average of chairs in the offices reported finds 1.7 easy chairs and 2.5 straight chairs available.

Sixty per cent of the administrators said their windows have draperies, 59 per cent said they have venetian

tures of family, 23 per cent; pictures of friends, 8 per cent, pictures of business acquaintances, 2 per cent, and planters, 29 per cent.

Fifty-one per cent of the administrators answering the survey are in charge of nonprofit hospitals, 26 per cent administer governmental hospitals, 21 per cent church affiliated nonprofit hospitals, and 2 per cent proprietary hospitals.

Few major regional variations were found in the breakdown of totals except those that would bear out trends indicated in the introduction, i.e. that administrators in the eastern half of the country have somewhat larger and more elaborate offices, though not necessarily more functional ones.

A few predictable variations are to be noted in comparing hospitals at opposite ends of the bed capacity scale. For instance, the bulk of the 50 bed hospitals have offices in the 15 by 20 foot class or smaller, while the hospitals of over 600 beds have a majority 15 by 20 feet or larger.

No administrator of a 600 bed hospital lacks a private office, while only 55 per cent of those in 50 bed hospitals enjoy privacy.

More than 90 per cent of the administrators of 50 bed hospitals who have private offices are located next to the general business office, while 90 per cent of the administrators of 600 bed hospitals have their secretary's office adjoining. #

## First they expanded the nursing school— then came students

MELVIN H. DUNN

Melvin H. Dunn has been director of Church Charity Foundation of Long Island and director of St. John's Hospital, Brooklyn, N.Y., for seven years. Effective June 1, he will leave New York to return to Kansas City, Mo., to become director of Children's Mercy Hospital.



Above: A contemporary student at St. John's writes a letter in her newly furnished, single room. Residence facilities have been expanded by 50 per cent.

The  
THREE-YEAR  
PROFESSIONAL  
NURSE  
COURSE

IT TAKES  
ONLY MINUTES  
TO INQUIRE  
ABOUT

St. John's Episcopal  
Hospital School of Nursing  
480 HERKIMER ST., BROOKLYN 13, N.Y.

The billboard shown above is an effective part of the new recruitment drive for student nurses at St. John's Episcopal Hospital, Brooklyn, N.Y. This sign was contributed to the hospital by a firm that specializes in outdoor advertising.

IN MAY 1956, St. John's Hospital, Brooklyn, N.Y., initiated a new approach to student nurse recruitment, and the increase in applications and enrollment has been overwhelming.

The first thing we did was to expand the student nurse facilities by 50 per cent, at a cost of more than \$500,000. You should have heard the Cassandras!

Next we appointed a program director, Ada McQuillen, the hospital's director of volunteers and public relations and former personnel director. Her new job is a full-time assignment, entailing not only recruiting student nurses, but guiding them through to acceptance and keeping them happy after enrollment.

Foremost among the plans was soliciting the cooperation and support of the professional staff. Under the leadership of Gloria Alicandri, director of nurses, the school overcame any "foot-dragging" on the project.

Next, a psychologist, Arthur D. Haggerty, was assigned to the school of nursing. In addition to teaching basic psychology to students, Mr. Haggerty serves as psychological consultant to the nursing committee, supervises administration of nursing aptitude tests, assists the faculty in promoting satisfactory adjustment of students, gives individual intelligence examinations. He also serves as psychological consultant for students with special problems, and screens out students who seem to need psychiatric consultation.

A four-page recruitment booklet was created. Entitled "Should You Be a Nurse?," it features on its cover a picture of a contemporary student at St. John's and the hospital's name and address. Page 2 is a word picture of an ideal nurse; page 3 states admission requirements, tells what St. John's has to offer, and gives a hint of the rewards of a nursing career. Page 4 invites parents and their daughters to visit the school.

We don't believe in "overselling" our school; we have found that prospective students who meet us at least halfway are the type most likely to succeed. The brochure is mailed in appropriate quantities to Episcopal clergy, guidance counselors, librarians and others.

## CASSANDRAS PROPHESED FAILURE, BUT THIS RECRUITING PLAN WORKED

AS APPLICATIONS come in—we are processing about 400 per year now—appointments are made through the program director's office. The prospective student is invited to spend an entire day at the school. We provide overnight guest facilities for out-of-town applicants.

While the applicant takes tests, her mother is given a tour of the hospital and school by Miss McQuillen. At noon the visiting girl lunches with students, usually freshmen. The freshmen have proved to be enthusiastic hostesses, showing off their rooms, the school, and recreational facilities. In the afternoon the girl finishes preliminary admission tests, and then is interviewed by the director of nurses and/or the nursing education director. The day ends in Miss McQuillen's office, where mother and daughter are encouraged to ask questions. Often some of the students stop by to chat, and we think that most of our prospects leave with the feeling that they have made new friends and with a desire to "belong" to our student body.

After the girl returns home, we keep up a constant correspondence, including some personal questions that will require a reply. There also are follow-up mailings of literature and invitations to school functions. In other words, we never abandon a good prospect; if she doesn't join us this year, she may next.

Final evaluation and selection of students is the function of Miss Alicandri and the nursing school faculty. When an applicant's folder is complete, it is submitted to Miss Alicandri, who meets with the committee on admissions, including Miss McQuillen and Mr. Haggerty.

Of course, the students are not neglected after they are accepted, or at any time during their three-year course. Happy and satisfied graduates are our best advertisement for more students and more graduates.

In September 1956, we graduated 25 nurses, who were replaced by 45 carefully selected students. In September 1957, 18 nurses were graduated; these were succeeded by 42 new students. But we processed nearly 400 applications each year to get this "cream of the crop." In 1938, only 44 per cent of student nurses admitted were graduated. In 1956, that figure rose to 80 per cent. We believe we are making some progress. We think the time, money and energy expended are well worth while and will continue to pay us dividends for many years to come. #

Top, right: Back cover of brochure.  
Center, right: A prospective student who visits the new nursing arts classroom will find that it is equipped with sterilizers, patients' call systems, dressing rooms, and other facilities to help her learn the art of being a nurse. Right: Chemistry is an important subject, and students have a new laboratory to work in.

### A Word to Parents:

#### HOW TO HELP YOUR DAUGHTER HAVE THE CAREER THAT SHE WANTS

Many factors will enter into your daughter's choice of a career: her interests, her ambitions, her abilities, the counsel she receives from her teachers, her friends, and from her family. But, most of all, it will depend on the opportunities she has to get the training she needs to enter the field of her choice. If she is thinking of professional nursing as a career, we suggest that you arrange for a visit to SAINT JOHN'S EPISCOPAL HOSPITAL SCHOOL OF NURSING. We are always willing to show prospective students, as well as teachers and parents, our modern homelike facilities. PLEASE let me know if you would need overnight accommodations, as this may be arranged by reservation in advance.

For further information, write to:

**PROGRAM DIRECTOR, BOX "A"**  
**480 Herkimer Street**  
**Brooklyn 13, New York**



# How to Get Along With Funeral Directors

A funeral director reviews some of the causes of conflict between hospitals and morticians, suggests ways to improve their relations, and issues warning regarding the hospital's ethical and legal responsibilities whenever a patient dies

W. L. BUSTARD

THE casual observer is likely to think that the function of a funeral director is solely to bury a body—an assumption as shortsighted as it would be to conclude that the hospital administrator has fulfilled his responsibility once the patient has been put to bed.

The body is very important, of course, but its greatest importance lies in the family's emotional attachment to the body—an attachment so real and so deep that the courts have defined the dead human body as the object having the greatest sentimental value of anything on earth. It is also important as a possible source of contagion or infection, so another aspect of our service is that of the sanitarian.

But our greatest service is to the living . . . to assist the bereaved through one of life's most trying periods. An irrevocable change occurs in the family's life at the death of one of its group; a multitude of strange problems arise and we must know the answers; endless details must be arranged and it is our duty to do all of the remembering.

The author wishes to express appreciation to James G. Carr Jr., administrator of Memorial Hospital of Natrona County, Casper, Wyo., for his contribution in establishing cooperation between hospital personnel and the morticians of this community.

There are many similarities in the physical operation of both hospital and mortuary. We both operate on a 24 hour schedule; emergencies are normal; the unexpected is routine, and we must anticipate the impossible; your personnel and scheduling problems would stagger me if I didn't have exactly the same problems; our financial problems are similar, too, with high overhead costs to meet and the necessity of caring for all, regardless of ability to pay; both of us deal with people in an abnormal state of mind and we deal with the same professional groups—but these things are obvious. The less obvious thing is that our efforts and results are far more similar than they appear on the surface and at the moment of death they coincide. For a brief interval we have a common problem and the hospital administrator plays a vital part in funeral service.

At that moment you have a responsibility of the greatest importance—the responsibility of being sure that the person lawfully entitled to the possession of the body receives possession as soon as possible and in the same condition as when death occurred.

The separation of the soul and body exists only in theology and theory and

the partial acceptance of this separation comes to the bereaved only with time . . . if ever. In life the body and soul were so inextricably intertwined that we human beings, who think with our emotions far more than our logic, cannot separate them immediately at the moment of death. Consequently the body, as the only surviving and visible portion of this unity, assumes even greater significance and becomes to most people their most precious possession. Therefore it is a matter of the most vital importance that you set up regulations to guarantee the next-of-kin's right to direct the care, custody and disposition of the body—including their right to a free selection of their funeral director—and that this right be granted without delay, interference or outside influence.

There are many reasons why this is necessary but all of them can be wrapped up in two general principles: The funeral director, like the physician, cannot render maximum service without the confidence, trust and respect of those he serves, so for the family's good it must be served by a funeral director whom it has freely chosen; second, a funeral service is one of the few things that must be done right the first time for it never can be done over again. Mistakes are permanent and never can be rectified.

These principles and the situations that can evolve from them must be considered in establishing the hospital's procedures at the time of death or, sooner or later, something will happen which will leave not only a psychic scar on the memory of some family but will leave a financial scar on your institution and some funeral director as well. The courts have held

Mr. Bustard, who has been associated in funeral service work since 1929, established his own service in Casper, Wyo., in 1937. This article is the outgrowth of a speech on the same subject that Mr. Bustard delivered to the Wyoming Hospital Association last year. He lectures each year on counseling ethics at the school of management conducted by the National Foundation of Funeral Service and talks to state groups on the use of color in funeral service. He is a member of the National Selected Morticians and National Funeral Directors Association.



that anyone who, by a fault of commission or omission, deprives the family of immediate possession of the body in the same condition as when death occurred is liable for damages and, in some cases, to criminal prosecution. You are well aware of the dangers of the unauthorized autopsy or surgery, but unauthorized embalming can be just as serious, and to deprive a family of possession by release to the wrong funeral director can result in astronomically high judgments for mental anguish. Remember, embalming is not merely a mechanical procedure and the skill of the operator is the greatest single determining factor for a successful operation; although the actual competence of both embalmer and funeral director varies greatly, as in any calling, there is even greater variation in the opinions and feelings of the individual family. You must surrender possession *only* to them.

Circumstances, conditions and legal aspects vary so greatly that it is not feasible to discuss specific regulations on a national basis. However, any set of regulations will be good if it has one goal, and one goal only: to guarantee immediate possession to the

person lawfully entitled to possession. Every effort should be made to guard against protecting any rights of anyone except that person, for the fancied rights of any other person are non-existent. Certainly no funeral director has any rights, nor do you, nor does a doctor or nurse or any other person, so if this is kept in mind you will have a good set of regulations.

I would suggest certain basic elements for any set of regulations now in force or to be adopted. They must be in writing and constantly available to everyone who conceivably could be involved. They should be reviewed with the hospital's legal adviser and contain a clear and concise definition of who shall be entitled to possession and under what circumstances, keeping in mind the now generally accepted legal principle that a person may direct the disposition of his own body, even over the desires of his family, provided his request is not dangerous to the public health, illegal or scandalous. The mechanics of notification and ascertaining preferences should be set out and the responsibility placed for carrying out your procedures. This responsibility should be specific for every hour of

the day or night and should be restricted to as few persons as possible, for divided responsibility is no responsibility.

Whenever a funeral director from another city is desired he should be telephoned, collect, immediately so that he may choose his local representative but you should set a time limit—one hour, for example—for him to give you his answer. Every release and the reasons it was so handled should be in writing over the signature of the responsible official and, in any case where the signature of the person claiming possession cannot be a part of your record, your personnel should state whose instructions were followed and how they were received. Everyone who could be involved must be familiarized with the regulations; there should be no possibility of anyone pleading ignorance of your rules.

Hospital personnel should not be permitted to make recommendations: a recommendation makes you, to a degree, responsible for the conduct of the mortician. In all instances where there is no choice, or no one to exercise it, a rotation pattern should be established among all of the reliable funeral directors of your area and I

## PROCEDURE TO BE FOLLOWED IN THE EVENT OF A PATIENT'S DEATH

### I. NOTIFICATION

The doctor is responsible for notification of next of kin or other persons in the event a person expires.

In the event of a patient's death the nurse in charge of the unit shall be responsible to see that a funeral director is notified under the following provisions:

1. Inquire of the nearest available relative as to their choice of funeral director.

2. If there are no surviving or available relatives, such inquiry shall be made of the person who appears to be a close friend of the deceased.

3. A "Release of Deceased Persons" form shall be made out in duplicate by the nurse responsible for calling the funeral director. The release shall be signed by either the next-of-kin or the person responsible for calling. When the next-of-kin does not sign, the person calling should state the reason why the particular funeral director was named. For example: "Mary Brown, R.N., by request of John Jones, father; or Mary Brown, R.N., verbal order of C. Jones, next friend; or Mary Brown, R.N., coroner's investigation; or Mary Brown, R.N., Body Unclaimed." This information shall also be included in the nurse's notes. The person accepting for the funeral director shall sign when the body is released and take the duplicate. The original will be attached to the patient's chart. If the body is unclaimed, call the nursing office to determine which mortuary is to be called in rotation.

In all cases where a next-of-kin or other relative is available, their choice of funeral directors shall be observed.

### II. NORMAL PROCEDURE

Under most circumstances the head nurse on the floor will proceed with the necessary notifications of the mortician. Where a doctor requests that the hospital assist in notifying relatives or in case of any other problem, the person in charge of the nursing office should be notified.

### III. CORONER'S INVESTIGATIONS

Deaths from criminal violence or from unknown causes which might be criminal, or deaths occurring without medical attendance are all cases that require coroner's investigations. In all such cases the coroner shall be notified before the body is removed from the hospital, but the choice of the funeral director shall be made by relatives in the same manner as for any other type of death. Usually the doctor or police will notify the coroner.

### IV. UNCLAIMED BODIES

Unclaimed bodies are those of persons expiring without available relatives or friends. Such bodies shall be rotated among all funeral directors with the sole exception of unclaimed bodies which might also require a coroner's investigation, in which case the coroner shall choose the funeral director.

### V. WELFARE PATIENTS

Welfare patients are to be treated in the same manner as are private patients, with the family making the choice of the funeral director. If no relative is available for selection of a mortician, the rotation pattern will be used.

### VI. SELECTING FUNERAL DIRECTOR

Hospital personnel should not recommend any funeral director under any circumstances. In instances where the relatives have no choice, the disposition of the body shall be the same as that for "Unclaimed Bodies" (Section IV).

No funeral director shall accept delivery until delivery order has been completed by hospital personnel as described in Section I.

In the event a funeral director from out of town is to be notified, a collect telephone call will be placed to the out-of-town director. He shall be asked what Casper funeral director should be called to pick up and hold the body for later delivery to the out-of-town director. If the out-of-town director has no choice, the body should be rotated among the Casper funeral directors. The body shall be delivered to a local director for delivery to the out-of-town director and shall not be held in the hospital pending arrival of the out-of-town funeral director.

Exceptions of any nature can only be made by a member of the hospital administrative staff or person in charge of nursing office.

### VII. DEATH NOTICES

Three death notices are to be prepared.  
Send one slip to the nursing office.  
Send one to the business office.  
Send one to the switchboard.

### VIII. IDENTIFICATION

Each body is to be identified. The name and the attending physician's name shall be written on a wide band of adhesive tape and adhered to the left wrist.

think it quite proper, even necessary, that you screen your funeral directors in much the same manner as you would determine which physicians are permitted to practice in your institutions. Such screening should not be arbitrary or capricious, of course, and should admit all reliable and ethical practitioners.

You should carefully investigate and determine the powers of the coroner or medical examiner in your area. Such powers vary greatly and in many areas certain nonlegal misconceptions exist; you could be held liable if you permit such an officer to usurp powers not rightfully his. In some jurisdictions he has the right of temporary possession; in others, only the right of access, but in every jurisdiction the family has the right of possession after the legal processes have been completed. Be sure of the law in your locality.

All this sounds like quite a program, doesn't it? Yet it can be accomplished easily. In our little city we have a fully approved, modern 245 bed hospital with the finest facilities; yet, for many years, the only rule for release was the rule of expediency. Headaches, heartaches and potential lawsuits were the natural consequences. However, five years ago, a series of conferences between the local funeral directors and the hospital administration resulted in the establishment of a system, tailored to the exact needs of the community and the institution, which is as nearly foolproof as any system can be.

#### DON'T GET TOO FRIENDLY

There will be difficulties, of course. Aside from human error you must guard against the friendship of personnel for certain funeral directors—a human failing but one filled with danger for both the administration and the funeral director. Be sure that no one develops a "board of equalization" complex and tries to divide all services equally among all funeral directors; this is proper only when there is no choice or no one to exercise it. Another pitfall is the tendency among a very small segment of the medical, nursing and hospital professions to view the body as only the waste product of a medical endeavor. Such people may assume that since the body means nothing to them it has no importance to anyone else, certainly a potentially explosive attitude. Above all, keep a strong central control with definite authority and responsibility.

Now let me make a few general observations. One is relative to the practice of closing all doors when we remove a body. If this is done it should be done by hospital personnel,

never by the funeral director, and I'm not convinced that it is a good practice, anyway. It must be quite obvious to the patients that a body is being moved but it makes it more mysterious and what they can't see they will imagine—probably something far worse than they would have seen. The ideal, of course, is to have orderlies remove the body on a surgical cart to a point near the ambulance entrance but that accentuates the help problem.

May I suggest, too, that delay in calling the funeral director not only multiplies his problems but can embarrass you and damage your public relations. Delay in embalming causes many difficulties, makes the results less satisfactory and, if the family calls us before we have been notified of the death, it doesn't reflect credit on your efficiency. Again, specific responsibility is the answer.

Although packing a body is desirable, the practice of tying the chin, replacing dentures and, occasionally, packing the eyes is not necessary and not even desirable. Tying the chin produces a mark which is very difficult to remove; the dentures must be removed to treat the membranes of the mouth and throat, and packing the eyes serves no purpose, so your personnel might as well avoid these duties. It is highly desirable, though, that nothing heavier than a sheet, if that, be permitted to rest on the face while the body is awaiting removal.

It would be well, I think, for the funeral director to give a receipt for the body in some inconspicuous place rather than have him too much in evidence in the more public parts of the building. This seems to run counter to my suggestion about closed doors but you will see my point.

If it is your practice to release the patient's personal effects to the mortician they should be itemized in duplicate, perhaps with a check list, and a receipt given, with a copy for the mortician.

If any of you experiences any trouble with funeral service people who do anything to disturb the atmosphere or operations of your hospital, report it immediately to the head of his organization. All reputable funeral directors would want to know of any such actions and, if they don't, you can always remove their name from your list of approved mortuaries.

Should any of you have funeral directors who seem to do too much visiting of the sick in your institutions it might be well to observe all of their actions quite closely. An excess of this sort of thing could amount to indirect solicitation, a highly unethical practice, so such persons might not be above attempting to influence your personnel to perform favors for them.

May I make a suggestion about autopsies? It is more than a coincidence that wherever arterial injection precedes the normal autopsy you find a happy relationship between hospital and mortician on this important subject—and you also find a much higher autopsy rate. We realize that certain autopsies, principally those in which bacteriology or toxicology are involved, should be done before injection but we most thoroughly agree with that large and rapidly growing group of pathologists who prefer to autopsy injected bodies. These men hold that arterial injection causes no difficulties and presents certain definite advantages: Postmortem changes and gravitation of blood are arrested, resulting in clarification of gross findings; circulatory disturbances are clearly defined; the technic is simplified and speeded without the necessity of guarding the circulation, and the pathologist can plan his day and autopsies better when freed from the pressures of a time schedule.

#### GET CONSENT TO AUTOPSIES

There are many ways this can be accomplished. In our city all autopsies are done in mortuary operating rooms and we furnish all desired instruments and equipment and take care of the postautopsy repair; in others, embalming rooms are provided in the hospitals, while, in some areas, the bodies are returned to the hospital for the autopsy. The important thing is that routine autopsies be preceded by arterial injection while the circulation is intact. If this is done everyone will be happy and you are assured of full cooperation and all the autopsies you could wish for. We, for example, are happy to obtain the family's permission in a high percentage of cases and find it is easier for us to get permission than it is for the hospital or doctor. After all, we have been entrusted with the care of the body and our recommendation, as an outside agency with no possible selfish reason for desiring an autopsy, carries much weight.

In any instance where an autopsy is to follow injection, or where the cause of death was infectious or communicable, the funeral director should be advised before the body is removed from the hospital.

I hope none of this sounds critical or fault-finding, for certainly it was not so intended, and I hope, even more, that hospital administrators may find something of value in it, something that will enable both of us to give better service to those who trust us. But no amount of writing can take the place of personal discussion. If you join forces your problems will disappear. #

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## Clues to Control of Hospital Infections

Success in controlling infections requires special attention to the arrangement of rooms and proper ventilation systems, housekeeping practices, laundry and isolation procedures

W. R. GEIDT, M.D.

**W**HAT kind of germ is the staphylococcus?

It takes the form of a sphere or ball measuring about 1/1000 of a millimeter in diameter. It grows in grape-like clusters and multiplies by dividing in two every 20 minutes under optimum conditions of heat, moisture, oxygen and food supply.

Staphylococcus germs are widely distributed throughout nature. That is, they are found almost anywhere—on skin, tables, in the air, on clothing, on the mucous membrane lining the nose and throat, in animals and in man. They survive for long periods of time when dried or protected by organic material.

The official name is *Micrococcus pyogenes*. Some families in this group are able to produce pigment which may be observed in colonies growing on artificial culture media. Some families produce a golden yellow pigment, some a lemon yellow pigment, and other families produce no pigment and therefore are white. So the group is divided into *Micrococcus pyogenes*, variety *aureus*; *Micrococcus pyogenes*, variety *citrus*, and *Micrococcus pyogenes*, variety *albus*.

However, there are other differences between staphylococci or micrococci

\*From the Division of Epidemiology and Laboratories, Washington State Department of Health. Acknowledgments are due to many persons who participated in the studies referred to, including Dr. Donald N. Wysham, an Epidemic Intelligence Service officer of the Public Health Service, as well as other personnel of the Communicable Disease Center of the Public Health Service; Dr. William Kirby of the University of Washington; Marie Mulhern, director of laboratories of the Seattle-King County Health Department, and many others on the staffs of the hospitals in the community.

Condensed from a paper presented at the Institute for Executive Housekeepers, sponsored by the Puget Sound chapter, National Executive Housekeepers Association, and the Association of Western Hospitals, October 1957.

than their ability or inability to produce pigment. Some of these germs are apparently harmless to the body; that is, they do not seem to grow well on the tissues or in the fluids of the body. However, others are capable of growing in body fluids or on tissues, and such growth calls forth a defense reaction of the body, usually resulting in production of signs of inflammation, such as heat, swelling and coloration of the area involved, and eventually the appearance of pus.

In addition to such local manifestations of pus forming infection, some staphylococci also are capable of manufacturing a soluble poison which, when ingested with the food or drink in which it has formed, may produce vomiting and diarrhea.

Generally speaking, even though staphylococci as a group have been considered relatively harmless, because certain strains were known to cause boils, carbuncles and other types of infection, as well as food poisoning, the germs have been divided into two general groups: Those that did not produce disease could be classified as benign and those likely to cause disease were classified as pathogenic. Apparently, both benign and pathogenic groups have been present ever since the staphylococcus was recognized as a distinct species of bacteria (1884). So why is there such a problem with them now?

Twenty years ago, the incidence of complicating infections occurring in hospitalized patients was rather common, and was recognized as a constant potential hazard. Yet, not more than five years ago, if the hazard was still present, it did not seem to be requiring much special attention—in fact, the situation seemed to be well under control through the application of

many refinements in technic combined with the use of prophylactic agents, such as the sulfonamides, beginning in the Thirties, followed by the use of penicillin and other antibiotics during the Forties.

During the last two or three years, an increased number of infections has been noted among hospitalized patients in many areas throughout the United States, Canada and England. We do not know whether an actual increase in the number of such infections has, in fact, occurred. But it appears that at least an increased number of them is being recognized. One of our problems is to attempt to find reasons to explain this apparent increase in order to develop measures which may keep such infections at a low minimum.

Let us consider the possible avenues by which organisms may be transmitted from various sources in such a way as to become lodged in sites suitable for propagation in the tissues of persons in hospitals, either personnel or patients.

Staphylococci have been ubiquitous for as long as we have been able to identify the species. The places in which they grow and are found are approximately the same today as they have been for many years. The avenues through which they have passed from one site to another are practically the same also.

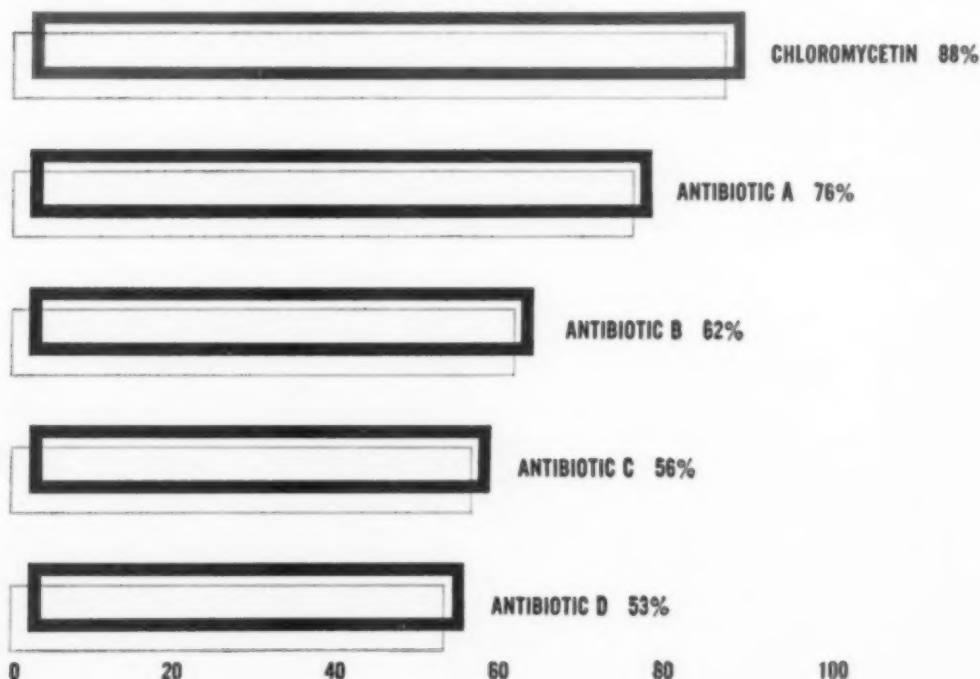
Our attention was called to "the staphylococcal problem" by Dr. William Kirby, professor of medicine at the University of Washington Medical School. Dr. Kirby had been engaged in making clinical evaluations of the efficacy of various antibiotics. To obtain the information he needed, he had arranged to study cultures of organisms which had been recovered

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\*Adapted from Ditmore, D. C., & Lind, H. E.: *Am. J. Gastroenterol.* 28:378, 1957. Organisms tested were isolated from stools of 48 patients.

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.



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from specimens submitted to the laboratory of a large general hospital in western Washington.

In reviewing the results of the clinical conditions of the patients involved, he noted that a number of the infections being treated had developed following performance of a variety of relatively simple surgical procedures, such as obtaining biopsy specimens of surface lesions, cutting down on veins to administer intravenous fluids or medication, catheterization and similar procedures. Furthermore, he was impressed by the fact that some of these apparently very minor infections occasionally became very serious processes, some of them terminating fatally. These serious cases, of course, were treated vigorously, but treatment was complicated by the fact that the organisms causing the infectious process were resistant to a number of the commonly used antibiotics.

What is meant by the phrase "resistance to antibiotics"? Possibly it may be easier to define what is meant by "susceptibility" to antibiotics. Essentially, if an antibiotic is capable of inhibiting the growth of a certain species of bacteria, it is said that this species is *susceptible* to it. If the organism is capable of multiplying in the presence of the antibiotics, it is said that the organism is *resistant*.

Five years ago, most of the strains of staphylococci prevalent at that time were *sensitive* or *susceptible* to the effect of penicillin. In certain localized areas this is no longer true. Many of the prevalent strains are resistant to antibiotics today. What has produced the change?

Dr. Vernon Knight and others have advanced the theory that antibiotic therapy eliminates the bacteria which are sensitive to the antibiotic used, thus enabling the remaining bacteria which are resistant to the antibiotic to become predominant. Although it is not generally accepted that antibiotics change organisms they are exposed to in such a way that they become resistant, the use of the antibiotic does contribute to the same end by providing a more fertile field in which relatively few, but already present, resistant organisms are enabled to flourish.

Reports may be found in the scientific literature of staphylococci isolated from animals found in the African veldt. It is highly improbable that these strains were made resistant by prolonged exposure to antibiotics. It appears likely that staphylococci do not *become* resistant to antibiotics—they either *are* resistant or *not* resistant.

In attempting to delineate pathways of infection of a commonly present organism, it is necessary to ensure that

the strains being traced are identical. Particular strains of staphylococci may be identified through observation of certain biologic characteristics. In our studies, strains were selected for study and classified as pathogenic if they were able to produce golden-yellow pigment on a special type of culture medium, and if these pigment producing strains regularly manufactured an enzyme capable of coagulating blood plasma. Such strains are referred to as being "coagulase positive."

However, further identifying procedures were necessary to enable us to determine whether a pathogenic strain of staphylococci obtained from Patient A was the same as the strain found in Patient B or Dr. X. We found two procedures upon which we could rely to determine whether organisms isolated from two different sources belonged to the same immediate family or not. Those procedures were (1) the antibiotic sensitivity tests, frequently carried out in hospital laboratories to determine what particular antibiotic should be used to treat a given patient, and (2) bacteriophage typing, generally shortened to "phage" typing.

#### DETERMINED PREVALENT TYPES

Our first study was made to determine how many types of staphylococci were prevalent. Material was obtained from personnel and patients of hospitals and from persons not associated with hospital populations or physicians' offices. It consisted of swabs or cultures from skin lesions or other infections of patients or from the noses and throats of patients and personnel.

It was demonstrated that about 25 per cent of the organisms were sensitive to all of the antibiotics and 25 per cent were sensitive to all but penicillin, and the remaining 50 per cent were resistant to two or more antibiotics, with considerable variation as to which ones.

While the results of this study did not appear to be very helpful, they indicated that there was a wide variety of specific types of staphylococci present in hospital patients and the community, that 75 per cent of these strains were resistant to one or more antibiotics, and that about one-fifth of these strains were identifiable as Phage Type 42B. However, we also learned something about identifying specific strains of staphylococci. We learned that the antibiotic sensitivity pattern was not sufficient to identify a strain; also, that two strains having the same phage type might not be identical. In other words, to determine the identity of strains, it is necessary to show that they have not only the same phage type, but also the same antibiotic sensitivity pattern.

To learn more about the development of staphylococcal infections in hospitals, it was decided to investigate a series of infections in a single hospital over an extended period of time. Arrangements were made with the hospital selected to follow up every culture found positive for staphylococci isolated by the hospital laboratory to obtain as much information concerning the circumstances of the infection as possible.

For the purposes of this study, only patients with definite infections with coagulase positive staphylococci were included. In the laboratory the staphylococci were isolated on blood agar. Hemolysis and pigment production were noted and coagulase production and antibiotic sensitivity were tested for each patient. In the meanwhile, information about the patient, including the history of his infection, was determined.

It was possible to place these patients into three general groups:

1. Those who had infections upon admission (acquired outside of the hospital).

2. Those who had no evidence of infection on admission, but who had developed infections while in the hospital.

3. Those whose infections appeared within 60 days after discharge from the hospital. The patients in this third group were discovered when they returned to the outpatient clinic or were readmitted.

This study was carried on for a period of approximately three and one-half months. A monthly average of 994 patients (including newborn infants) were admitted during this period. A total of 189 patients were found to have coagulase positive staphylococcal infections during that period, an average of about 55 infections per month (5.5 per cent infection rate).

No doubt, additional infections occurred which were not included because cultures had not been submitted to the laboratory. To check on this, 111 consecutive general surgical operations in this hospital were studied. The records of 25 per cent of these patients indicated infection. And in 10 instances, or 36 per cent of the infected cases, cultures were not taken.

#### Group I

Fifty-seven of the patients (30 per cent of the total) acquired their infection outside of the hospital and prior to admission. Most of these were skin infections, such as carbuncles or infected abrasions which had been treated in the outpatient clinic. There were also other infections, such as urinary tract infections, otitis media, and lymphadenitis. Two of these patients died, one of septicemia and the

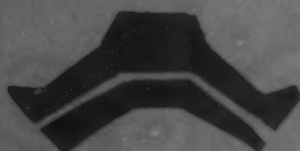
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other of meningitis preceded by carbuncles.

**Antibiotic Sensitivity.** Forty per cent of these infections were caused by organisms sensitive to all antibiotics; 35 per cent were resistant to penicillin only; 20 per cent were resistant to tetracycline, streptomycin and penicillin, and the remainder had resistance patterns other than indicated above.

### Group II

One hundred patients (53 per cent of the total studied) acquired their infections during hospitalization. These patients had been in the hospital anywhere between two days, as in the case of a newborn infant, to 13 months as in the case of a convalescent poliomyelitis patient. The median interval between admission and appearance of infection was 10 days. Twenty-six of the infections were surgical wound infections. Five of these patients died. Twelve of the patients developed staphylococcal pneumonia, eight of whom died. Six patients developed primary septicemia, three of whom died. All of these latter cases of septicemia had received intravenous medication prior to this development; a femoral catheter was used in one instance, a venous "cut-down" in two, and continuous intravenous therapy in another.

In this group there were skin infections in 18 infants, as well as breast abscesses in two mothers and two infants.

The remainder of the infections in the patients of this group consisted of decubitus ulcers, infected burns, urinary tract infections, and parotitis. Twenty-one of the 100 patients in this group died.

**Antibiotic Sensitivity.** Only three per cent of the staphylococci infections in this group of patients were sensitive to all antibiotics; 12 per cent were resistant to penicillin only; 36 per cent were resistant to tetracycline, streptomycin and penicillin. Twenty-six per cent were sensitive only to bacitracin and the remaining 24 per cent had a variety of other sensitivity patterns, most of them being resistant to two or more antibiotics.

### Group III

There were 32 patients in this group. Their infections appeared during a period varying from two to 60 days after discharge from the hospital. Ten of these patients developed infection of surgical wounds; eight were infants who developed skin infections, and four mothers and one infant developed breast abscesses. There was only one death in this group. The patient died of surgical wound abscess.

**Antibiotic Sensitivity.** The sensi-

tivity pattern of the staphylococci isolated from the patients in this group resembled the pattern found in the hospitalized patients. Three per cent were sensitive to all antibiotics; 6 per cent were resistant only to penicillin; 61 per cent were resistant to tetracycline, streptomycin and penicillin, and the remainder had a variety of resistance patterns other than those indicated above.

### Phage Typing

Forty per cent of the 58 cultures that were subjected to phage typing were found to be untypable. Twenty-four per cent (14 cultures) were typed in nine different phage patterns. The remaining 36 per cent (21 cultures) were in a group characterized by the pattern 52/42B/44A. This particular pattern has been associated with many recent outbreaks of staphylococcal infections in nurseries throughout the U.S., and in this study, eight of the cultures were obtained from infections of newborn infants or their mothers.

### NURSERY STUDY

An intensive study was carried on in a newborn nursery in a certain hospital. The aseptic technic carried out in this nursery could be considered excellent by recognized standards. However, our study was carried out during a period in which staphylococcal infections of the infants were prevalent. Cultures of the employees working in this nursery disclosed that they were *not carrying the same type of staphylococcus* which was causing the infections of the infants. The mothers of the infants were all cultured upon admission and every day thereafter until discharge. None of them had the organism on admission, but some of them acquired it during their period of hospitalization. Cultures of the *nose and throat and skin* of the infants were also made daily. While the mothers and personnel could be ruled out as sources of the infection, the infants themselves were highly infected! And when a mother became infected, the infection was detected in the infant first or on the same day the mother's cultures were found to be positive. Where was the reservoir of infection?

With the use of a type of air sampler through which measured amounts of air in the nursery could be drawn, it was shown that when the nursery was quiet, the air was relatively free of pathogenic staphylococci, but during periods of lusty crying or bed changing, the numbers of pathogenic staphylococci increased sharply. Other tests also confirmed our theory that *the infants themselves were the chief source of the continued presence of*



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the organism, and that the *infection was air-borne*. Thus, even the best aseptic technics could not completely prevent the spread of the infections in the nursery.

On the basis of these studies, it appeared that the pathogenic staphylococci must have been introduced into the nursery at some time, most likely by personnel, but that the personnel did not seem to play a major part in maintaining the prevalence of the organism. Two factors seemed to be more important: One was the presence of many bacteria on the bed-clothing, which were dispersed into

the air during bed changing. And the other was the *relative concentration of large numbers of organisms in the nursery* through having so many infants living in the same room (crowding).

Thus it appeared that at least one factor in the dissemination of the infecting organism (crowding) might be partially controlled by reducing the number of infants that could be cared for in one room. Actually, the incidence of infection of infants decreased rapidly when rooming-in care was provided.

Our observations of contamination of blankets in the nursery led us to

investigate blankets in other parts of the hospital. We found that practices commonly carried out in distributing, collecting, storing and laundering of blankets in some hospitals could contribute to the dissemination of organisms. Furthermore, Canadian and English workers have shown that *mattresses* and *pillows* also may serve as sources of infection.

Many so-called "aseptic technic" procedures have been developed to prevent cross infections in hospitals. Such technics are based on the proposition that it is possible to delineate "clean" and contaminated areas, then protecting the "clean" areas from contact with contaminated or potentially contaminated objects. The utmost in aseptic technic is generally carried out in connection with brain or bone surgery. In surgery much emphasis is placed upon *hand washing*, wearing rubber gloves, gowns and masks, careful sterilization of equipment and materials that may come in contact with the surgical wound, special treatment of the skin over the surgical site prior to incision, and efforts to keep the air as free of dust as possible.

Even the elaborate rituals established in most operating rooms may include practices that are not necessarily technically sound, although they may be highly respected, and their execution tends to produce feelings of great security. This is particularly true when some mysterious chemical is used in the ritual. It is feared that too much faith has been placed in the effectiveness of some of these chemical germicides. Unfortunately those who use these germicides are not always well acquainted with the limitations of the product and so it is sometimes used under conditions which neutralize its effectiveness. Most of these germicides have been developed on the basis of tests carried on in laboratories under strictly controlled conditions. The manufacturer can claim effectiveness under those conditions—but these conditions are certainly not the same as those which exist in hospitals.

Regardless of whether there has or has not been an actual increase in the number of infections occurring in hospitals, we feel that the information about the epidemiology of these infections which has accumulated provides valuable clues to be followed in reducing the present incidence and maintaining better control of them. Success in this direction requires special attention to certain features of hospital construction, such as arrangement of rooms; proper ventilation systems; housekeeping practices, particularly related to bedding, cleaning and laundry, and isolation procedures.

## Everybody's talking about Staph...

... and with good reason. Staph is a *real* trouble maker. *Staphylococcus aureus*—to be more formal—is vicious. It invades every part of the hospital. Wherever there are people, it can multiply. In dust, staph lives for weeks waiting to re-infect.

Once staph gets on the loose, there's no telling where it may turn up next... operating rooms... nurseries... patient rooms... laundry... food service. Among insidious troubles it can cause are postoperative wound infection... staphylococcal pyoderma... puerperal mastitis... staphylococcal pneumonia and enterocolitis.

(Editor's note: In fact, staph infection can pave the way for strep infection, too. If strep gets into a wound with antibiotic-resistant staph... parenteral penicillin won't stop or prevent strep infection even when the strep organisms are penicillin sensitive.)

Stopping staph troubles—or never letting them start—that's the problem. Careful attention to *total* environmental asepsis... critical evaluation of disinfection procedures and the disinfectants used... is an important part of the answer.

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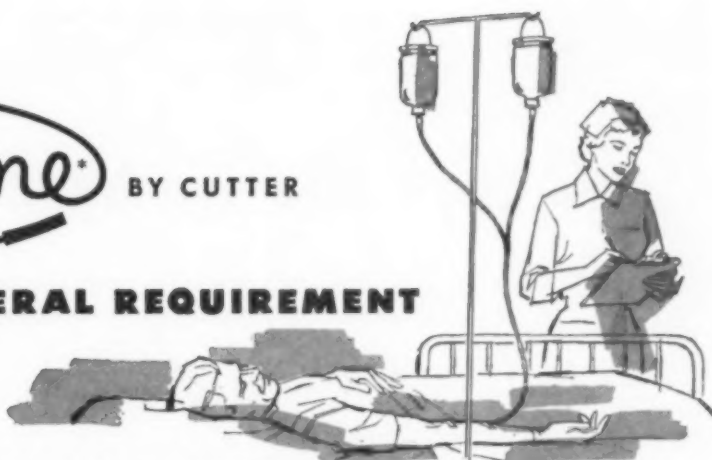
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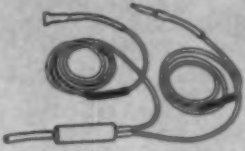








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# We Can't Hire Employees Ready-Made

**A training program is necessary to reduce turnover and waste, increase efficiency, and raise morale.**

**The author tells how to recognize the problems and set up a program that is simple but effective**

**JEAN SHAFFER**

**T**RAINING is the process of transferring information from one person to another so that the trainee can perform a job satisfactorily and safely in the least amount of time. As the late Dr. Frank Crane, journalist and educator, has said, "Teaching is lighting a lamp—not filling a bucket." To that might be added, in order to light a lamp successfully, it is sometimes necessary to fill it with oil and trim the wick.

So it is with training. It is not enough to say one day, "We are going to have a training program," and then pick some innocent dishwasher as a victim. All training must begin with knowledge of the facts and needs of a given situation. From this, the scope of training is determined. Ask first, "What do I want to accomplish?" Is it to improve some old method, discover new talent, or increase Mary's efficiency in serving the hot roast beef sandwich on the cafeteria counter?

It is sometimes difficult to recognize the problem. A good training program can break up bottlenecks, reduce turnover, raise morale, increase efficiency and production, prepare employees for promotion, make supervisors better job instructors, reduce spoilage and waste, and reduce acci-

dents if the problems can be recognized. For example, often an employee is paid overtime to complete a job when, instead, he should be trained to organize his work so he can get it done in the allotted time.

Work overloads are a common cause of bottlenecks in food service areas. A supervisor cannot tell by looking at a worker or by walking through an area occasionally whether a worker is performing above or below standard. To determine the equality of work distribution, a sampling must be taken over a period of a week or longer observing more than one worker doing a specific job. A standard work load can then be established.

Another problem that can be partially solved by training is flexibility of employees. This can be accomplished by cross training so that at least two people know how to do every job and then do it frequently enough to remain familiar with its responsibilities. Often what appears to be a small problem on the surface has its beginning in weakness of management which only the dietitian or someone higher in the line of authority can remedy. For example, a dishwasher may be reprimanded because the glasses do not sparkle

when actually the pressure on the rinse line is so low they cannot be properly rinsed.

When the problem has been recognized and the objective established, the training person should then consider how long the training will take, what personnel will be involved, what equipment will be used, and so on.

For the past few years the University of Kansas Medical Center has employed an inservice training dietitian. This dietitian's responsibilities include the orientation of new employees, daily classes with employees, work simplification projects, time and motion studies, and a variety of special assignments.

Approximately three hours are spent by the training dietitian in orienting a new employee. The orientation period includes a detailed explanation of the employees' handbook. This provides an opportunity to explain department objectives, policies and rules. Pay rates, promotions, vacations and sick leave are discussed. Laundry procedures are explained; uniforms are issued; lockers are assigned, and a physical examination is scheduled. After a tour of the areas with which the employee must become familiar, including locker rooms, laundry, cafeteria and food production, the employee is introduced to the people with whom he will work and is then dismissed to return when his job is scheduled to begin. During the orientation a special effort is made to introduce the new employee to the director of the department.

For classes, the employees are divided into groups of from eight to 12 people. An effort is made to have the groups made up of people who do similar types of work. Classes are

*Jean Shaffer knows whereof she speaks in discussing training in the dietary department. She is employee training and education dietitian at the University of Kansas Medical Center, Kansas City, Kan. She took her undergraduate degree in dietetics and institutional management at Kansas State College. Following a dietetic internship at Scripps Metabolic Clinic, La Jolla, Calif., she worked for the state of Illinois as the chief dietitian at Anna State Hospital, Anna, and as dietitian at Manteno State Hospital, Manteno.*



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scheduled during the employees' working period, and attendance, while not compulsory, is expected. The classes last about 20 minutes and each employee attends once every two weeks. In order to see all employees this frequently, the training dietitian must conduct two classes each day. Food standards, portion control, safety, sanitation, personal appearance and hygiene, and attitude are the subjects of classroom teaching.

Techniques used in the teaching have included group discussion, rôle playing, and problem solving in order to increase employee participation. Films, demonstrations, posters and flannel-grams have also been helpful to the dietitian in teaching these classes. Visual aids have proved useful when they perform a function rather than merely provide entertainment.

#### OBSERVES TROUBLE SPOTS

When a supervising dietitian has a personnel problem that needs special study or has an employee with faulty work habits, she calls upon the training dietitian to help her study the problem and decide upon a course of action to remedy or at least improve the situation. The training dietitian attempts to gather the pertinent facts, usually by observing and working in the troubled area. Using these data and the background experience of the training and supervisory dietitian, the two work together to arrive at an acceptable solution and a method of carrying it out.

Special assignments for the training dietitian might include such a variety of duties as showing a movie and scheduling all employees to see it, holding individual conferences with dietitians or employees, teaching dietetic interns, planning a holiday celebration, or devising a way of recognizing employee achievements. A considerable amount of time is spent on such activities as these, many of which are designed primarily for general morale improvement.

In an effort to evaluate and improve the training program at the University of Kansas Medical Center, a questionnaire was sent to 62 hospitals. Almost all of the hospitals questioned have internship programs since it was felt that they would be the ones most likely to have a dietitian in a training position. The questionnaire was designed to determine the hospital staff's attitude toward employee training in their own situation. How important is employee training? Who should do the training? How much time should be spent? If there was a training dietitian, could she do other closely related duties such as job analysis, hiring and ratings?

Of the 54 questionnaires returned, only five institutions reported that they employ a training dietitian. All hospitals that returned the questionnaire did some employee training. The amount of time varied according to the need. There seemed to be the feeling that the dietitian and her associates (either nonprofessional supervisors or experienced, dependable employees within the work area) should be responsible for training. Others felt an employee training dietitian would be helpful but their budgets would not allow them to hire this person.

#### THERE MUST BE HARMONY

This brings up the discussion of the merit of one training person for the institution as opposed to the supervisor-in-unit doing the training. In order to discuss this, the terms staff and line employee must be clearly understood. Staff employees recommend, develop, advise, while line employees enforce or carry out. For a department to have a trainer in a staff position, the training program must have been developed in conjunction with the line employee's concept of the job and how it is to be done. If there is harmony between these two people—an understanding of the what, how and when of the job—and if the employee understands to whom he goes for help when the trainer leaves, the training can be effectively done by a training dietitian.

Increases in efficiency and production up to 75 per cent have been credited to training in the field of industry. Cannot this do the same in the field of dietetics?

It has been said, "You can buy an employee's time, his presence at a given spot, and compel him to do a certain amount of work, but you cannot buy his loyalty, respect, enthusiasm or will to work." The individual's best efforts are brought out by leadership, not drivership. It is not enough for dietitians to want cooperative attitudes from employees; they must work to gain this cooperation by being democratic leaders. They must be living, breathing good examples. Nothing is so infectious as example. Effective training requires understanding, interest and cooperation from personnel on all levels. It cannot be separated from but is rather an essential part of supervision.

An important point is that the dietitian must know more about each job than the person assigned to do it. When a supervisor really knows how, daily rounds will actually be training periods. When she goes through the kitchen and finds the soup kettle boiling merrily with the steam on full and the lid up, she will stop long enough

to explain why stock should be simmered, not boiled, and why the lid should be closed. These things must sometimes be repeated day after day, and with variations, but that is the essence of supervision. If the desirable degree of understanding, interest and cooperation is attained, employees will be recognized as individuals, not as pot and pan washers. They will feel free to talk over personal as well as work problems with their supervisors and they will make suggestions for improving their jobs. A line of communication must be kept open.

In an effort to improve communications with employees and attain the ultimate goal of improved food service to patients, an employee attitude survey was conducted at the Medical Center. It was hoped that this survey would show the true feelings of employees toward their job, their supervisors, the hospital administration, and general working conditions. All 200 employees took part in the survey by answering a questionnaire. The employees were seated some distance apart and no discussion of questions was permitted. The employees from a single unit were polled at one time. All answers were assured the strictest anonymity. The feeling toward supervision and the supervisor's understanding of employees varied greatly in the different units. The over-all attitudes of employees in the smaller units were generally more favorable than those of the employees in the larger units.

#### HOW TO USE INFORMATION

How can this type of information be put to use? Realizing that employee attitudes are a decisive factor in the success of the department, the director shared the information acquired by this survey with the dietitians and supervisors in the various units. In employee classes, the results of the questionnaire were discussed. If the results from such a questionnaire are evaluated and discussed cautiously and democratically, they can be most helpful.

A trainer is one who can get people to do what he wants done, when he wants it done, in the way he wants it done, because *they* want to do it. He must continually increase his skill in training by developing new and better methods. A trainer must be constantly alert to avoid some common pitfalls of his profession. He must avoid the tendency to teach too fast. Every job should be broken down into important steps which are presented to the learner one at a time, clearly and patiently.

The successful trainer does not proceed to the next step until he is sure the trainee thoroughly under-

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stands the operation being presented. The trainer must remember to explain *why* things are done in a certain manner. The *why* is a protection for it helps to ensure that the job will be done right. Trainers must remember to express themselves clearly in terms that the trainee will understand. If technical words must be used, they must be explained in a simple, concise way. It is hard for the trainer to remember that procedures that are so familiar to him are usually completely foreign to the new employee. For example, words like "purée," "marinate" or "conveyor" probably

have no meaning to a new food service worker.

Training in how to do a job does not call for any complicated organization, but must include a really clear concept of what the job entails, the proper order in which it is done, what utensils and materials are needed, and the key points to remember. The training is, of course, not complete without a follow-up after the initial instructions are given. A word should be included about the improperly trained employee who must be taught the proper methods. Two operations are required—one to undo faulty

habits and one to teach the right way.

How do people learn? In order to train more effectively, every trainer should be familiar with the nature of learning. One fundamental must be recognized as basic to all learning: All that we know, we have learned through the five senses. Sight is the most important, for 85 per cent of all learning is gained through this sense. Seeing the products, seeing the operations, seeing the chart, all contribute greatly to the speed of learning. Hearing is next in importance. The trainer's voice, the discussions, and comments are mediums by which trainees learn.

Feeling or the sense of touch is another medium through which we learn. Merchandise is often sold through the customer's judging the quality of the merchandise by feel. Smelling accounts for little learning, but can be extremely important. The smell of gas or of something burning calls for quick action. Taste is a highly important sense in the dietetics profession but may be a minor sense insofar as learning in general is concerned. Obviously a trainer will use training methods involving as many of the five senses as possible, but especially the two most important: sight and hearing. Both must be used extensively.

There are four basic steps used in teaching any job.

1. **Preparation:** Put the learner at ease, find out what he already knows, show importance to his success, analyze and know the job to be taught.

2. **Presentation:** Tell, show, and tell why in correct sequence; present one step at a time, clearly; present no more than learner can master.

3. **Performance:** Have learner try his hand and tell what and why he is doing each step; observe and correct his errors at the time they occur; repeat instructions if necessary.

4. **Follow-Up:** The learner is assigned to the job and told to whom he will go for help should he need it. Check from time to time to see how well the information is retained and used.

Through all teaching keep constantly in mind that a knowledge of human relations is just as important as knowledge of the job. The formula for good human relations is to be "fair, firm and friendly."

How do you start a training program? Start where you are. Do not wait for a rosy future where someone else trains employees or where people automatically change and become the type of employees everyone wants. Every worker brings to his job a certain capacity for growth and it is well to remember that good employees can only be developed, they cannot be hired ready-made. #



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## Administrators Have a Vested Interest in Recruitment of Qualified Dietitians

**N**URSES are not the only professional group in short supply in the hospital field. Trained, qualified dietitians are just about as hard to find and, like nurses, they make an essential contribution to patient care.

Since 1947 the American Dietetic Association has had a national career guidance program to stimulate interest in the field but the program needs the assistance of hospitals, which have a large stake in recruiting dietitians since they employ approximately 50 per cent of the membership of the American Dietetic Association.

In cooperation with the association's career drive this year, The MODERN HOSPITAL asked several administrators to discuss the reasons hospital administrators have a special interest in recruiting qualified women into dietetics as a profession and recruiting trained dietitians into hospital careers, and also to describe effective recruitment techniques they have used. The replies of three of these administrators are presented here.

### Important to Case Management

**T**HERE has been considerable emphasis on hospital careers recently and, Heaven knows, the dietitian is needed. The emphasis on diet therapy in the physician's case management becomes more pronounced each year.

With dietitians in short supply and with the demand growing with the years, we in the hospital field must again emulate industry and seek to encourage development of those skills necessary for effective hospital operation.

**R. Mark Stanton**  
Director

**Charlotte Hungerford Hospital**  
Torrington, Conn.

### Way to Promote Recovery

**G**OOD food service is one of the successful ways of promoting patient recovery and of ensuring everlasting gratitude for a pleasant hospital experience. This can be accomplished in a hospital where the administrator has an awareness of patient needs and his reactions to how and what he is served. To develop a topnotch service, several steps must be followed.

1. Employ a qualified dietitian.
2. Cooperate in making inservice education available.
3. Encourage young people to enter the field.

The economic factor in the national shortage of qualified dietitians was faced up to and action was taken to upgrade the salary level. This kind of recognition is of considerable importance in stimulating interest in this field. Unqualified and half-trained people may try to serve, but it is not wise to expect a high-grade, comprehensive service. Theoretically, the shared dietitian or part-time dietitian sounds ideal for solving small situation problems but, somehow, not only is this service too scarce, it is also unrewarding. We live in a community of three hospitals. There has been no development for extending such a program because the large hospitals are understaffed in the first place.

Administrators must depend on dietitians for quality and quantity; for adopting new practices and techniques; for serving food in accordance with accepted standards and within budgetary allowance. A qualified dietitian must have a wide range of knowledge, including organization and operation of all units within the dietary department, its theory and practice; she must know physiology, special nutrition needs of a wide variety of diseases, and bacteriology as it relates to food and sanitation.

To recruit dietetic students, the administrator can be helpful by cooperat-

ing in various ways. National Hospital Week presents a good opportunity to bring the public a better understanding of such careers. Our women's auxiliary presented a narrative skit each day in a different high school, acting out each career as it dovetailed in the care of a patient. Descriptive literature obtained from the national association was distributed. Question and answer periods conducted by administrative assistants evoked a very interesting response.

We have had the state food service expert lecture to our women's auxiliary on various aspects of diets and have helped set up attractive exhibits at health fairs depicting the work of a qualified dietitian.

Hospital tours can be arranged where the dietitian is able to demonstrate the functions of her position in a very attractive manner. More interest can be stimulated by working through various groups, such as parent-teacher associations or mother-father groups, and by showing films inviting them to an attractive hospital dietary environment. Where a crisp, clean, cheerful and efficient food service exists, interest in the work is definitely stimulated.

**Pauline Nussbaum**  
Administrator  
**Park City Hospital**  
Bridgeport, Conn.

### Recognize Importance of Job

**I** AM tremendously interested in the recruitment and training of qualified hospital dietitians and food supervisors. I have worked diligently toward that end at hospitals in Norwalk and Stamford, Conn., and here at Brewster.

At Brewster we have an A.D.A. dietitian and also an administrative dietitian who has had considerable experience. Unless hospitals have properly educated A.D.A. material in the dietary field on the job, the medical staff is greatly discouraged. In so many medical cases, food in itself and, certainly, the proper kind of food is of so much importance that only a doctor or a dietary therapist can prescribe.

It seems to me that I have simply been lucky to have qualified A.D.A. members on the staffs of the hospitals with which I have been connected. I do not have any particular gimmick or technic for recruiting. I suspect, however, that if we have fared better than other hospitals, it is because we have recognized the importance of the job.

**Jack H. Whittington**  
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**Brewster Hospital**  
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# Menus for May 1958

<p><b>1</b></p> <p>Sliced Oranges Bacon, Fruit Twist</p> <p>Bouillon Beef Noodle Casserole Buttered Zucchini Tomato and Cottage Cheese Salad Apricot Whip, Custard Sauce</p> <p>Tomato Juice Sautéed Liver With Brown Gravy O'Brien Potatoes Buttered Carrot Rings Heavenly Hash</p>	<p><b>2</b></p> <p>Pineapple Chunks Soft Cooked Egg, Toast</p> <p>Clam Chowder Western Omelet Buttered Peas Creamy Cabbage Lemon Puff</p> <p>Cream of Asparagus Soup Baked Tuna and Vegetable Casserole, Biscuit Crust Lima Beans Tomato-Olive Aspic Chocolate Nut Ice Cream</p>	<p><b>3</b></p> <p>Blended Juice Shirred Egg on Waffle</p> <p>Mulligatawny Soup Chicken Tetrazzini Brussels Sprouts Fresh Fruit Salad Coconut Pudding</p> <p>Grilled Ham Slice, Orange Sauce Creamed Potatoes Mexican Corn Head Lettuce Wedge Fruit Gelatin With Whipped Cream</p>	<p><b>4</b></p> <p>Cherry Juice Sausage Patties</p> <p>Grape Juice Roast Sirloin of Beef Stuffed Baked Potato Buttered Wax Beans Beauty Salad Graham Cracker- Pineapple Pudding</p> <p>Chicken Noodle Soup Welsh Rabbit Over Broiled Tomato on Toast Points Asparagus Spears Molded Fruit Salad Oatmeal Cookies</p>	<p><b>5</b></p> <p>Stewed Apricots Poached Egg on Toast</p> <p>French Onion Soup Spanish Rice, Bacon Vegetables Macedoine Fruit and Cauliflower Salad Butterscotch Ice Cream</p> <p>Baked Pork Chop Apple Dressing Sweet Potato Surprise Spinach au Gratin Cherry Crisp With Nutmeg Sauce</p>	<p><b>6</b></p> <p>Grapefruit Sections Bacon, Raisin Toast</p> <p>Split Pea Soup Macaroni and Cheese Casserole Broiled Tomato Half Tossed Spring Salad Lemon Snow</p> <p>Cream of Chicken Soup Epicurean Hamburger Hot German Potato Sandwich Celery Sticks Fresh Fruit Cup</p>
<p><b>7</b></p> <p>Applesauce Soft Cooked Egg</p> <p>Vegetable Juice Chicken à la King on Toast Points Julienne Carrots Banana Nut Salad Peach Half</p> <p>Orange Juice Roast Shoulder of Veal, Gravy Potato Casserole Buttered Green Beans French Apple Pie</p>	<p><b>8</b></p> <p>Stewed Fruit Compote Bacon, Date Muffins</p> <p>Cream of Asparagus Soup Fried Chipped Beef With Scrambled Eggs Pan Browned Potatoes Sliced Tomato and Cucumber Salad Boston Cream Pie</p> <p>Corn Chowder Pepper Steak Over Egg Noodles Buttered Sliced Beets Strawberry Ice Cream</p>	<p><b>9</b></p> <p>Orange Juice Scrambled Eggs</p> <p>Tomato Rice Soup Cream Cheese and Olive Sandwich on Whole Wheat Bread Potato Chips Deviled Egg Salad Blitz Torte</p> <p>Salmon Croquettes, Parsley Sauce Diced Potatoes Buttered Peas and Sautéed Mushrooms Raspberry Salad Fudge Pudding</p>	<p><b>10</b></p> <p>Banana Corn Muffins</p> <p>Cream of Vegetable Soup Barbecued Pork on Sandwich Bun Waldorf Salad Gingerbread-Pear Upside Down Cake</p> <p>Beef Pot Roast, Vegetable Gravy Oven Browned Potato Creamed Corn Perfection Salad Lemon Filled Eclair</p>	<p><b>11</b></p> <p>Grapefruit Juice Ham, Pineapple Muffins</p> <p>Cream of Spinach Soup Baked Stuffed Green Peppers Broiled Tomato With Mushroom Cap Layered Gelatin Salad Blueberry Buckle</p> <p>Country Fried Steak Duchess Potato Succotash Marinated Asparagus Sautéed Sesame Seed Rolls Sliced Pineapple</p>	<p><b>12</b></p> <p>Baked Apple Scrambled Eggs</p> <p>Beef Broth With Seashell Noodles Corned Beef Hash Chili Sauce French Fried Potatoes Apple Spodie With Whipped Cream</p> <p>Roast Leg of Lamb, Mint Jelly Parslaid Potatoes Julienne Carrots Pink Pear and Cream Cheese Salad Maple Nut Ice Cream</p>
<p><b>13</b></p> <p>Grape Juice Bacon, Biscuit</p> <p>Orange-Mint Cocktail Chicken Fricassee on Fluffy Rice Broccoli Spears With Buttered Crumbs Cranberry Jewel Salad Banana Cream Pie</p> <p>Ham Loaf, Mustard Sauce Broiled Marshmallow Sweet Potato Whip Spinach Soufflé Cheese Apple Crisp</p>	<p><b>14</b></p> <p>Stewed Prunes Bacon, Doughnuts</p> <p>Vegetable Juice Seafood Newburg in Pattie Shells Buttered Green Beans Peach-Cheese Salad Baked Raisin Rice Pudding</p> <p>Baked Ham With White Raisin Sauce Baked Corn Pudding Paprika Cauliflower Strawberry Soufflé Salad Peach Lattice Pie</p>	<p><b>15</b></p> <p>Orange Slices Sausage, Toast</p> <p>Spaghetti Caruso Brussels Sprouts Lettuce With French Dressing Bread Sticks Tutti Frutti Ice Cream</p> <p>Blended Citrus Juice Broiled Veal Chop Cranberry Glaze Hashed Potatoes Stuffed Onions Melon Ball Salad Marble Cake</p>	<p><b>16</b></p> <p>Stewed Apricots Soft Cooked Egg</p> <p>Tomato Bouillon Broiled Mackerel Creamed Peas Panama Salad Date Bread Pudding</p> <p>Tuna Mousse Deviled Eggs Over Spinach Noodles With Cheese Sauce French Fried Eggplant Lemon Sponge Cake</p>	<p><b>17</b></p> <p>Peach Nectar Poached Egg on Toast</p> <p>Vegetable Soup Fluffy Turkey Turnovers, Giblet Gravy Green Beans Creole Waldorf Salad Cranberry Meringue Pie</p> <p>Shepherd's Pie With Fluted Potato Border Asparagus Spears Pineapple-Prune Salad Baked Crumb Custard</p>	<p><b>18</b></p> <p>Banana Ham, Sticky Pan Buns</p> <p>Roast Pork Loin, Cider Gravy Escalloped Sweet Potatoes and Apples Relish Plate Cherry Ice Cream</p> <p>Cream of Chicken Soup Chili With Macaroni Buttered Wax Beans With Green Pepper Tomato-Celery Aspic Green Gage Plums</p>
<p><b>19</b></p> <p>Applesauce Chipped Beef on Toast</p> <p>Corned Beef With Horseradish Sauce Steamed Cabbage Grapefruit-Cheese Salad Apricot Halves</p> <p>Meat Croquettes, Pickled Relish Gravy Creamed Diced Potatoes Glazed Cinnamon Carrots Vegetable Salad Devil's Food Cake, Mocha Frosting</p>	<p><b>20</b></p> <p>Orange Halves Soft Cooked Egg</p> <p>Pineapple Juice Cheeseburger on Bun French Fried Potatoes Pear Salad Black and White Pudding</p> <p>Roast Duck Celery-Apple Dressing Stuffed Potato Tomatoes and Onions Banana Salad Lime Sherbet</p>	<p><b>21</b></p> <p>Prune Juice Bacon, Pecan Rolls</p> <p>Beef Broth Julienne Swedish Meat Balls Fluffy Irish Potatoes Cottage Cheese Salad Golden Cupcake With Orange Icing</p> <p>Lamb Curry Over Crispy Noodles Cheddar Carrots Sliced Cucumber Salad Fudge Sundae</p>	<p><b>22</b></p> <p>Orange Juice Sausages on Waffles</p> <p>Braised Shortribs, Horseradish Sauce New Potatoes Steamed Cabbage Wedge Spiced Apple Salad Prune Pudding</p> <p>Chicken Gumbo Soup Ham-Broccoli Roll, Egg Sauce Corn Fritters, Sirup Tomato Tower Salad Nutmeg Applesauce</p>	<p><b>23</b></p> <p>Strawberries Poached Egg on Toast</p> <p>Cream of Celery Soup Cheese Fondue Fresh Tomato Sauce Asparagus Spears Carolina Salad Danish Apple Pudding</p> <p>Tomato Juice Baked Perch Fillets, Lemon Butter Snowflake Potatoes Wild Endive Peach-Bonbon Salad Coconut Layer Cake</p>	<p><b>24</b></p> <p>Baked Apple Bacon, Hot Biscuits</p> <p>Creole Soup Cold Sliced Corned Beef With Mustard Swiss Cheese, Rye Bread Club Luncheon Salad Peaches and Cream Pudding</p> <p>Veal Birds, Mushroom Gravy Chantilly Potatoes Breaded Eggplant Molded Bing Cherry Salad Fresh Fruit Cup</p>
<p><b>25</b></p> <p>Apricot Nectar Pancakes With Sirup</p> <p>Roast Beef Franconia Potatoes Buttered Carrot Strips Cabbage, Pineapple, Marshmallow Salad Fresh Plum Cobbler</p> <p>Cream of Vegetable Soup Toasted Bacon and Cheese Sandwiches Buttered Lima Beans Sliced Tomato Salad Black Walnut Ice Cream</p>	<p><b>26</b></p> <p>Orange Juice Scrambled Eggs</p> <p>Broiled Liver, Onions Whipped Potatoes Fresh Tomatoes Lettuce Wedge With 1000 Island Dressing Apple Cobbler With Lemon Sauce</p> <p>Pineapple Juice MacGregor Casserole Asparagus Spears Molded Strawberry Salad Fresh Fruit Cup</p>	<p><b>27</b></p> <p>Blended Juice Soft Cooked Egg</p> <p>Chicken Alphabet Soup Breaded Veal Cutlet With Tomato Sauce Escalloped Potatoes Buttered Peas Citrus Fruit Salad Ice Cream, Butterscotch Sauce</p> <p>Mushroom Soup Frankfurter in Spanish Sauce, Roll Potato Salad Purple Plums Sugar Cookie</p>	<p><b>28</b></p> <p>Stewed Prunes Cinnamon Toast, Bacon</p> <p>Vegetable Soup Ham à la King on Toast Rounds Julienne Green Beans Blueberry Crisp With Whipped Cream</p> <p>Savory Swiss Steak Snowflake Potatoes Stewed Tomatoes and Diced Eggplant Jack Strawn Applesauce</p>	<p><b>29</b></p> <p>Grapefruit Half Poached Egg</p> <p>Navy Bean Soup Toasted Bacon, Tomato and Lettuce Sandwich Fluted Potato Chips Celery Sticks Filled With Cheese Frosted Brownies</p> <p>Irish Stew With Cornmeal Dumplings Buttered Broccoli Orange and Pecan Gelatin Salad Butterscotch Cream Pie</p>	<p><b>30</b></p> <p>Apricot Halves Poached Egg</p> <p>Tomato Soup Baked Halibut Diced Potatoes Buttered Peas Sunshine Salad Chocolate Pudding, Whipped Cream</p> <p>Cream of Mushroom Soup Tuna Casserole With Biscuits Mixed Vegetables Tossed Salad Apple Pie With Cheese</p>
<p><b>31</b> Prune Juice, Bran Muffins • Minestrone Soup, Spaghetti With Italian Sauce, Parmesan Cheese, Asparagus Tips, Relish Plate, Citrus Fruit Cup • Cranberry Juice, Southern Baked Chicken, Giblet Gravy, Honey Glazed Yams, Paprika Pearl Onions, Peach Crumble With Whipped Cream.</p> <p>Ready-to-eat or cooked cereals served on all breakfast menus.</p>					



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## MAINTENANCE AND OPERATION

An examination of the value of air conditioning and a look at the various possible methods that may be used. The author recommends the central unit where possible



A central station absorption refrigeration machine provides chilled water for under-the-window control cabinets.

### *Air Conditioning Benefits Entire Hospital*

REID T. HOLMES

THERE is no question that air conditioning has become a valuable aid to the achievement of satisfactory medical results in the modern hospital. Inquiries made of top level staff members at North Carolina Baptist Hospital, Winston-Salem, N.C., in a position to evaluate the differences in their various departments in the year following installation of an all-season air conditioning system, elicited these comments:

Mr. Holmes is administrator, North Carolina Baptist Hospital, Winston-Salem.

The chief of professional service said air conditioning permits longer periods of intense surgery. Both patient and operating staff have been found to be more comfortable and relaxed. The problem of hypothermia during extended surgery has been virtually eliminated because of the patient's ability to radiate excessive heat in a temperature and humidity controlled operating room. (Previously, hot summer months restricted "elective surgery" because of heat retention by surgical patients.)

From the anesthesiologist's point of view, the use of oxygen tents no longer poses the problem of gas concentration or excessive heat. More effective ether anesthesia is possible, inasmuch as ether vaporization is best controlled in an air conditioned operating room where relative humidity is maintained at less than 55 per cent. The use of anesthetic gases in general has been made considerably safer through controlled humidity and conditioned fresh air.

In diagnostic studies, such equipment as the electroencephalograph or electrocardiograph provides more accurate data by virtue of the absence of skin perspiration (which normally impedes good electrical contact).

"Certainly no department in the hospital has derived as much life-saving benefit from year-round air conditioning as the pediatrics ward," in the opinion of the chief of pediatrics.

Prior to air conditioning, the children's ward experienced a regularly scheduled "watering period" for administration of fluids lost through dehydration in hot and humid weather. At present the need for fluids among children has been cut by two-thirds.

Infant skin rash aggravated by excessive humidity and air-borne lint has been reduced by circulation of conditioned air throughout the building, night and day.

Patients suffering from burns are better able to endure dressings, since excessive humidity is no longer present to irritate skin tissues.

The benefits from air conditioning provide improvements in every department of the hospital, and actually speak for themselves. Nevertheless, in planning an air conditioning system,

#### AVERAGE INSTALLATION AND OPERATING COST BREAKDOWN

Costs for complete year-round air conditioning may vary depending upon the individual hospital building's requirements. Given a typical nonprofit, short-term general hospital with: (1) 100 square feet of space per bed in the nursing unit; (2) 24 hours per day, seven days per week, 100 per cent occupancy—the air conditioning industry suggests the following general guide as to average installation and operating costs.

	Typical New Bldg.	Typical Old Bldg.
(A) Initial air conditioning cost per square foot	\$3.85	\$4.62
(B) Principal and interest at 5 per cent for 20 years (A times .08)	\$0.308	\$0.370
(C) Insurance at 1 per cent (A times .01)	\$0.039	\$0.046
(D) Owning costs per square foot per year (B plus C)	\$0.347	\$0.416
(E) Operating costs per square foot per year	\$0.413	\$0.413
(F) Air conditioning owning and operating costs per square foot per year (D plus E)	\$0.76	\$0.83

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what are some of the alternatives faced by the hospital administrator?

1. **Window units.** These units create a minimum of annoyance; they are quickly installed and offer a flexible installation pattern.

Filter characteristics leave much to be desired for hospital requirements; temperature and humidity control is not as precise as is true with central equipment. Coils, condensers, fans and motors are all located in the room. Noise level can become erratic with use. Maintenance and repair problems are disturbing to the room occupant. Except for hospitals in the most southern climates, auxiliary heating is required.

2. **Self-contained units.** The on-off operation cycle of this equipment may not provide the constant humidity and temperature control desired in a hospital. In addition to consuming space, the fact that air from various rooms is mixed together and then recirculated is of primary concern. This is highly undesirable because of the risk of spreading contagious disease through air-borne microorganisms. An auxiliary heating system is usually required.

3. **Underwindow fan coolers.** Outside air is obtained by cutting a hole through the exterior wall of each room or by means of a snorkel extension over the window sill. Dehumidification of the air is done in the units; excessive condensate can upset control conditions and be a source of odors. As with window units, each unit contains its own fan and motor, which can cause maintenance and noise problems.

4. **Central station air conditioning.** Baptist Hospital selected a high velocity, spiral conduit system featuring individual temperature control in each room. Cooling and heating at desired conditions is obtained (year-round) through a slim cabinet enclosed in the wall with no mechanical devices to maintain or create noise.

Heart of the system is an absorption refrigeration machine (300 ton capacity) installed on the sixth floor in surplus attic space of the hospital's newly built wing. Using low-pressure steam as the energy source to provide chilled water for circulation throughout the building, the machine's vibrationless operation is quiet enough to go unnoticed by occupants of the surgical suite located directly below.

The absorption type of refrigeration was ideally suited to the hospital's needs, inasmuch as an abundance of steam was already being produced for the laundry, kitchen, sterilizers and other domestic hot water requirements. During the summer when steam demands are lower (absence of building heat), optimum boiler loads are maintained with the aid of steam actuated absorption equipment. In addition, the machine functions efficiently at partial load. Purchase of a single machine with sufficient capacity for the present wing and proposed expansion saves cost of two machines and two installations. Water lines in any new construction need only be connected to existing large-capacity piping.

Chilled water produced in the apparatus room is pumped to the individual under-the-window cabinets in the patients' rooms and administrative offices. Outside air, conditioned in the sixth floor apparatus room, is sent at high velocity through slim conduit ducts to the same air control cabinets. As the centrally conditioned "primary air" passes through a scientific pattern of ejector nozzles within the cabinet, a quality of "secondary" or room air is induced to flow into the unit over coils through which the chilled water (heated water, in winter) is circulated. The secondary air is cooled or warmed to compensate for temperature factors within the room. An automatic mixing valve permits the room's occupant to control the flow of chilled (or hot) water and

select his own room temperature independent of the comfort level being maintained next door. Each room has its own conditioned air supply as well as separate exhaust grilles. No air is returned to the central system. This eliminates the passing of contaminated air from room to room.

Despite the magnitude of an installation of this kind, the entire hospital was equipped with air conditioning without any major disruption of patient or staff routine. No room was disturbed for more than one or two hours.

In crucial areas, such as operating suites, installation was made on Saturday. When acute surgery cases were brought in, the movement of crews was coordinated with activities of the surgical staff to avoid conflict.

The installation began in August 1955 with removal of a 34 year old heating-piping network. Seven weeks later heat was available to every room in the hospital through the system. Prefabricated duct work was used to avoid unnecessary hammering and form fitting within the hospital building. This effected a tremendous saving in installation time and cost. (The entire job was completed in April 1956.) Cost of installation will be amortized through "increased census" over a 10 year period. At present there is an extensive waiting list for hospital accommodations which, in large part, is the result of the existence of air conditioned facilities. Patients requiring other than emergency care will actually delay hospital admission until space is available.

Throughout the hospital and community in general, staff and patients extoll the virtues of year-round air conditioning. Personnel functions more efficiently; turnover has been reduced. Patients enjoy speedier convalescence which in turn results in a more widespread use of hospital facilities by the community as a whole. This, of course, means increased revenue. #

Units in the patients' rooms at North Carolina Baptist Hospital are installed flush with the walls under the windows.



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# Black Light Illuminates a Floor Problem

This new technic employs black light and fluorescent dye to determine whether the protective coating on soft floors is really there or whether the "film" is just a high gloss

KENNETH W. MASTERSON

IS IT possible to "see" a transparent film, such as the coating that is formed by a floor finish? Obviously not—under ordinary lighting conditions—and yet a great many housekeepers and maintenance men believe they can tell whether a floor is properly coated just by looking at it. What they actually see is the surface of the flooring, and what leads them to believe they see the protective film in most cases is the gloss that results from buffing. Of course, if finish has been recently applied, it is safe to assume that it is still on the floor; but if the film has been down for some time, particularly in heavy traffic areas, such an assumption may be quite unjustified.

The author was a chemical engineer for the Research Division, Public Buildings Service, General Services Administration, when he devised this method of fluorescent analysis of water emulsion of floor finishes. He is now a chemist for Vestal Laboratories, Inc.

Unless they are adequately protected, soft flooring materials, such as rubber and asphalt tile, linoleum and so forth, are easily damaged by dirt, friction from foot traffic, and spilled liquids. The purpose of the water emulsion finishes is to interpose a coating that will reduce wear and tear on the floor as much as possible.

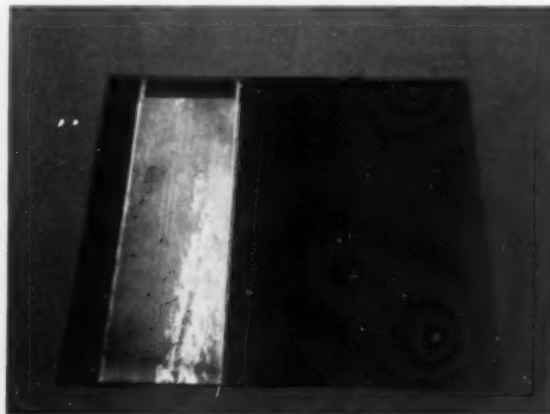
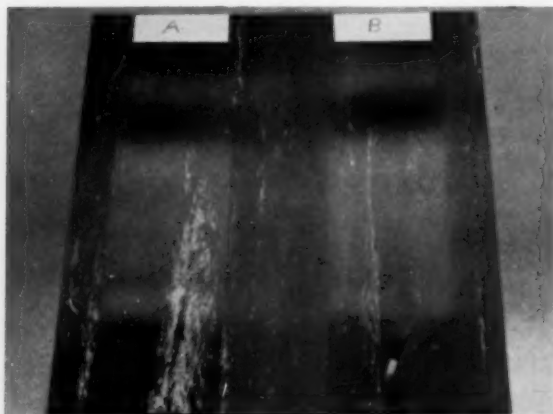
### SELECT PROPER FINISH

It is, therefore, extremely important for both the manufacturers of flooring materials and those who must maintain them to be sure that the proper protective finish (one which has a high degree of wearability) is selected; that the finish is replaced when it has been worn down; that it gives a level, even surface, and, finally, that the finish can be stripped off when necessary.

A method by which the film, or lack of it, on the floor surface actually can

be seen has recently been developed. The technic employs black light fluorescent tubes, a water-soluble fluorescent dye—and a solution of the emulsion to be tested. The tubes are constructed of a special filter glass that absorbs virtually all of the visible light and transmits a high percentage of the near-ultraviolet light. Such tubes can be obtained in wattages of 4, 6, 8, 15, 20, 30 and 40 and in corresponding lengths of 6, 9, 12, 18, 24, 36 and 48 inches. They can be used in an ordinary fluorescent fixture. The long wave ultraviolet energy of black light is harmless to eyes and skin.

The most successful dye, selected after considerable experimentation, is Rhodamine B, used in concentrations of 0.3 gram per quart of emulsion. The dye colors the emulsion and the films red and is visible in ordinary light. (Cont. on Page 112)



Left: Water emulsion wax containing a fluorescent additive was applied to Panel A of tile. Panel B was merely buffed to a gloss equal to that of the wax film. In ordinary light, viewers believed both panels to have wax film. Right: As seen under black light, however, it becomes obvious that protective film covers only Panel A. Gloss alone does not reliably indicate presence of wax film.



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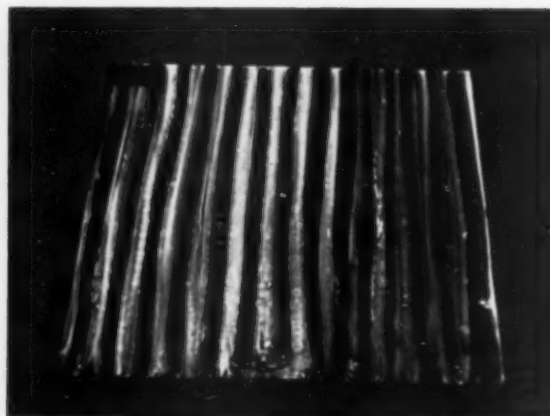
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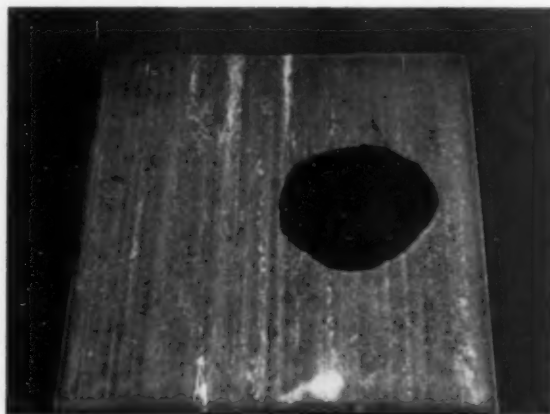
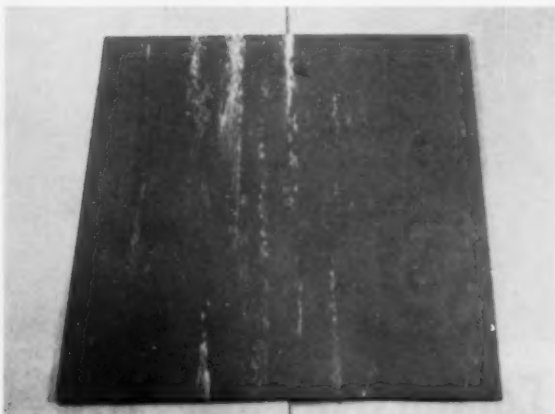
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Above, left: A floor finish used on this tile was rated excellent for leveling as judged by the uniform and streak-free surface appearance of the film. Above, right: Under black light, it becomes apparent the finish used did not level. Black light reflects from bare surfaces caused by film drying to alternating ridges, furrows. When there is little film in furrows, finish wears quickly.



Above, left: Floor finish on left side of tile was thought to be removed after wax remover was applied, since gloss was gone. When part of finish at right of tile was treated with wax remover, finish was judged still present. Above, right: Under black light, the opposite was true. Left side was not removed; right side was, as shown by black spot where dewaxer was applied.

(Continued From Page 110)

When the dye is added to the floor finish it will settle to the bottom of the container and begin to dissolve; complete solution is best observed in a clear glass container, such as a bottle. The color of the emulsion changes from pink to a medium shade of red, and when solid red particles are no longer seen at the bottom of the bottle, the dye is completely dissolved. Stirring reduces the time for solution. If dye is added to emulsions in cans it should be done the day before use to ensure complete solution.

Small test panels can be used in making comparative tests of floor performance, as shown in the photographs on these pages. Fluorescent films can be applied with a folded

gauze swab; excess liquid should be removed from the swab so that the film applied will be of moderate thickness.

If testing for leveling properties is done on new tiles, the factory finish should be removed. Scrubbing with fine steel wool, dipped in a wax stripper, usually will do this.

Tests for removability of finish should be made on aged films, which can be simulated by storing the panels, with films already applied, at 50° C. for 24 hours. The test panels then should be partly immersed in a wax stripper solution for five minutes, hand scrubbed with a cellulose sponge for 20 strokes, rinsed, and examined under black light. The effectiveness of an unproved wax stripper also can be

tested in this way. Such a test should use a floor finish that is known to be removable by a proven wax stripper.

These tests for leveling and removability can be used to eliminate further testing of some floor finishes. Those that do not level or cannot be removed are substandard products and will not stand up well in more extensive floor performance tests. A panel test for removability also prevents later use of a finish that cannot be removed from the floor.

The most suitable areas for testing floor performance of finishes are corridors and halls that have about the same amount of traffic traveling in both directions. (There should be at least 500 to 1000 trips made through the area daily.) The floor



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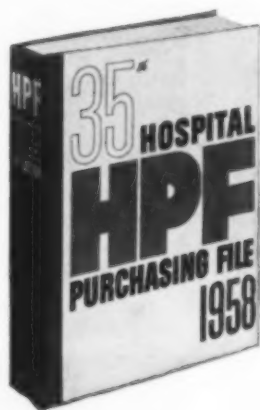
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Lake Shore Markers, Inc.

Lynn-Sign Molded Plastics Co., Inc.

Jas. H. Matthews & Co.,  
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Michaels Art Bronze Co., Inc.

Micro X-Ray Recorder, Inc.

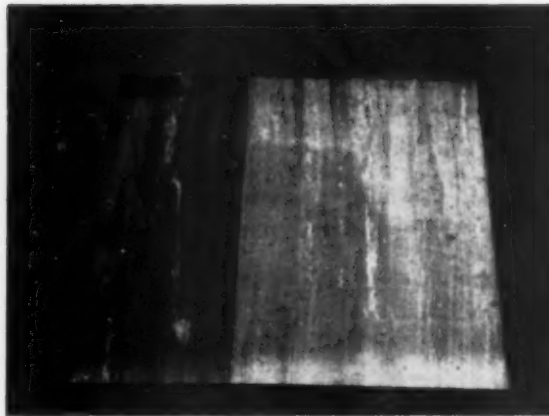
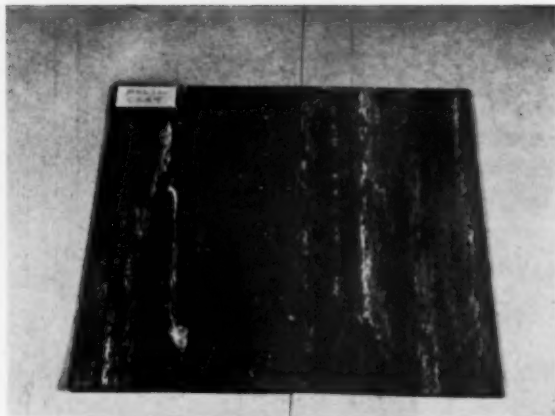
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Physicians' Record Co.

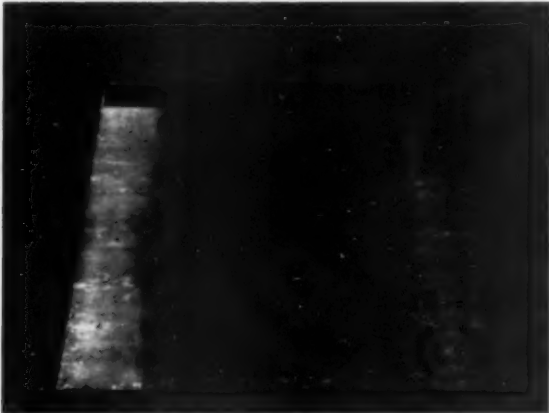
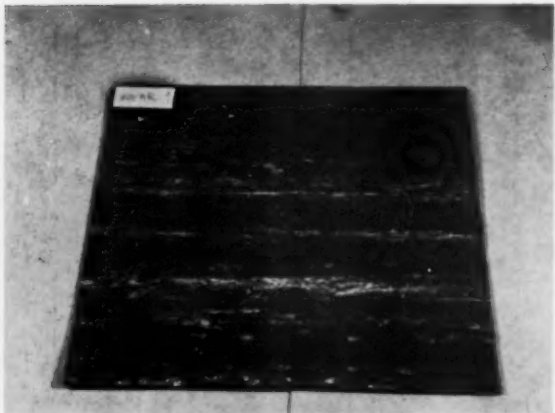
Recordak Corporation,  
Subsidiary of Eastman Kodak Co.

Spencer Industries

United States Bronze Sign Co., Inc.



Above, left: In a demonstration of the number of coats of finish on floor surfaces, viewers could not, in ordinary light, discern whether one coat or two coats had been applied. Above, right: When the tile was viewed under black light, however, the two-coat application at the right of the tile was apparent. The thicker the film of finish, the brighter is the fluorescence visible.



Above, left: Here, the finish was hand rubbed with fine steel wool to produce a form of abrasive wear. The film, when examined the usual way, did not seem worn, looked as if it had been polished. Above, right: Black light shows film worn away where rubbing was done. Appearance is like that of floor on which fluorescent film of finish has been worn away by foot traffic.

should be thoroughly cleaned and stripped of wax before an emulsion is applied. A gallon of emulsion, put down with a lambswool applicator, should be used for every 1500 square feet of floor surface. After the films have dried for one hour, they can be buffed. Damp mopping should be done every day.

Each week the fluorescent test films should be examined and evaluated by usual methods for slip resistance, scuffing, gloss, buffability and dirt retention (on light colored floors). Wearing qualities should be tested by black light in darkened surroundings.

Observation of films by black light are most successful in dark areas, since the darker the area, the brighter the fluorescence. The black light source

will give off a small amount of visible blue light, which will be reflected from films and floor surfaces. This reflection can be reduced by directing the black light at certain angles to the film or floor.

The degree of brightness under fluorescence varies with the formula of the finish. Most finishes will produce bright fluorescent films, but the ingredients of some have a "quenching" effect on fluorescent substances. Therefore, degrees of wear should not be compared between types of finishes. Instead, each finish should be tested separately for wearability, by noting the percentage of wear on a film near the walls of a corridor and the same type of film on the center section, where traffic is heavy.

The Rhodamine B dye is suitable for testing finishes and wax strippers on test panels and on dark colored floors. However, since it has a red color, visible in ordinary light, it may not be desirable for use on light colored floors. It is possible, however, to incorporate into floor finishes fluorescent dyes that do not produce any visible color. Then the maintenance superintendent need only inspect the floors with black light to determine (1) whether application of finish was complete and even; (2) whether proper leveling is attained; (3) how the finish is standing up under use and when reapplication is necessary, and (4) whether finish has been completely removed in stripping operations. #



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## You Know What You Mean But Who Else Does?

(Continued From Page 54)

addition to the various points mentioned regarding "instructions") always establish clearly and at an early stage that the recipient of the request accepts an obligation to comply with the request. If he has no such intention, there is little point in pursuing details of the request itself, and therefore the first point to be established in these cases is the question of *responsibility*. If the recipient of the request accepts responsibility for compliance, then there should be little difficulty, except that checking on action might be a little more delicate than in the case of a direct instruction.

A useful gambit in dealing with many requests for action is to place as much of that action as possible upon the shoulders of the person requesting it, on the ground that he is presumably the person most interested in the making of the arrangement.

For example, if Dr. X (a surgeon) requests the hospital administrator to alter his operating session from Wednesday morning to Friday afternoon, and to do this will mean that other surgeons (Dr. Y and Dr. Z) must make some alteration in their timetables, there is much to commend the idea that Dr. X should approach Dr. Y and Dr. Z direct and if they are prepared to make the change, the administrator will agree. This simple method has the advantage of shortening the lines of communication, eliminating the administrator who, in such a case, is little more than a "middleman," and bringing face to face the two potentially divergent interests. If Doctors X, Y and Z do not reach agreement, then a state of affairs has arisen in which the administrator must intervene, but the question then becomes one of administrative technic rather than of communications.

The final main category of communications is advice and opinion (the other two were "information" and "instruction"). Little new need be said about this category of communications, but it is worth repeating that, once again, the main point is clarity.

If the sender of a communication (whether verbal or written) wants advice or opinion, he should ask for it and indicate broadly upon which particular points advice is required, and, similarly, the person responding to a communication should be very careful that any advice or opinion he gives is clearly recognizable as such, and is not in danger of being confused with fact. Whether or not advice should be tendered if not specifically

requested depends so much upon particular circumstances that a clear rule is not possible, and any decision must turn upon the merits of each particular case.

At the one extreme, it is the duty of every person to take reasonable steps to prevent misunderstanding and confusion and if the tendering of unsolicited advice or opinion would do this, it is probably justified.

At the other extreme is the fact that unsolicited advice is very rarely well received (perhaps because it carries an implication that the recipient has overlooked or misunderstood something) and, therefore, this particular commodity should be employed somewhat sparingly.

Where advice or opinion is requested, it should be given fully and lucidly, and it may in some cases be necessary to distinguish between advice given in an official capacity and advice given in a personal capacity. It is, of course, to be remembered that many senior officers, such as hospital administrators, are by the very nature of their profession expected to give advice and opinion at all times, and there is no suggestion that officers such as these shall hesitate to give advice if this seems to be within the general sense and understanding of their employment.

Much more could be said upon this question of communications, and many further distinctions and subdivisions of the foregoing points could be elaborated. (There is, for example, a considerable distinction between "advice" and "opinion," though for most practical purposes they may be regarded as similar.) It is hoped that the foregoing analysis may be regarded as at least one valid approach to the general principles of communications, and virtually everything that has been said is really a variation upon the basic theme of clarity.

If the subject had to be summed up in one sentence, it could be stated quite simply that all communications, of no matter what nature, must be *absolutely clear*. The most vital aspect of this essential clarity is deliberately left until the end, although there has been ample opportunity in the foregoing to refer to it. The point is so vital, so obvious, and yet so frequently overlooked at such great cost, and it is that any communication of any category, written or verbal, must be *absolutely clear to the recipient*.

Many completely worthless communications are crystal clear to the sender. That is comparatively easy, but it is not enough. It is the sender's job to make sure that any communication (written or verbal) which he sends will be *clear to the recipient*. That is administration. #

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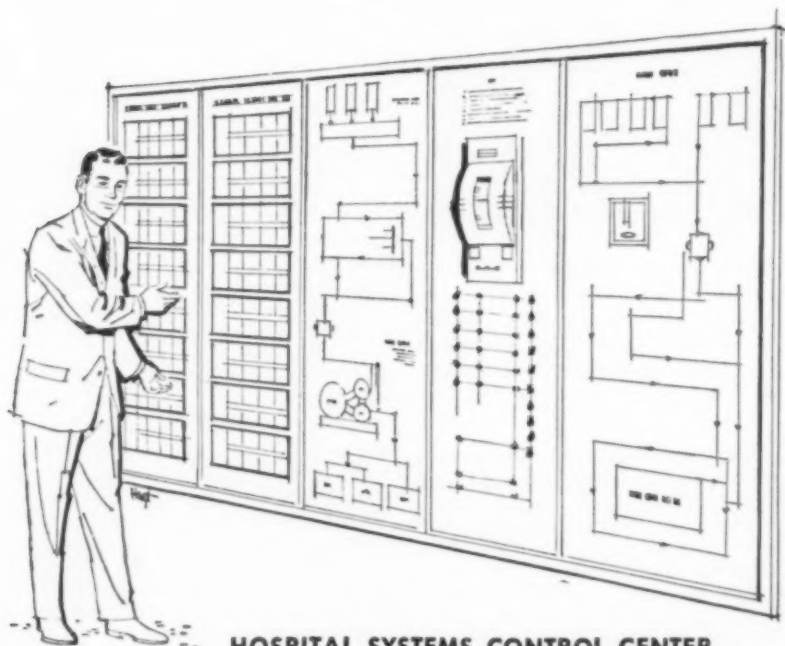
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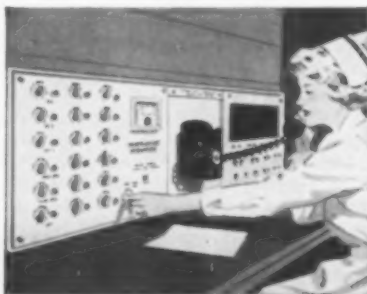
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## NEWS DIGEST

**Hospitals Have No Recession, Ohio President States . . . New Jersey Labor Leaders Oppose Blue Cross Increase in Rates . . . Alabama Delegates Hear Candidates for Governor Discuss Health Problems . . . G.P.'s Seek End of Discrimination**

### No Recession in Hospitals, Ohio President Tells 1900 Delegates to Annual Meeting

CINCINNATI.—"There's no recession in hospitals," Wayne B. Foster, president of the Ohio Hospital Association, told some 1900 delegates to the 43d annual meeting of the association here last month.

"Hospitals are busier than ever, and if the living standard of Americans continues upward, so will the cost of operating hospitals," Mr. Foster said, naming advances in medical technics, high labor costs, increased use of hospitals, and care of the aged as reasons.

At the opening session, Robert C. Haynie, assistant to the president of Champion Paper and Fibre Company, predicted that by 1965 there will be 30 million more people who will need food, clothing, shelter and hospital-medical care, plus 18 million people over age 65 who will present special needs. Industry, hospitals and the medical profession must cooperate to provide health needs for everyone or the government will step in to do the planning, Mr. Haynie said.

There will be no interns in the hospitals of 1965, said Dr. Karl S. Klicka, director of Presbyterian-St. Luke's Hospital, Chicago, and Dr. Robert M. Zollinger, chairman of the surgery department at University Hospital, Columbus.

Hospitals will have resident and staff doctors only, they said, and the internship program will be made part of medical school training.

Self-service rooms for ambulatory patients, completely motorized beds that patients themselves can control, and hotel-like private rooms with adjoining showers, wall television, and music piped in through pillow speakers will be included in the hospitals of the future, the delegates were told.

Closed-circuit television, which will transmit a picture of the patient in his room to a nurse at the central nursing station, also will be a part of future hospitals, the doctors predicted.

The money to build the "dream hospitals" will come from the community, plus matching funds, on a 33 per cent basis, from the federal government, Dr. Klicka said.



Officers of the Ohio Hospital Association, left to right: president-elect, Anthony S. Dickens; president, Roger Sherman; past president, Wayne B. Foster, and the executive director of the Ohio association, Harry Eader.

Hospitals of the future will be bigger—from 800 to 1000 beds, Dr. Zollinger predicted.

Anthony S. Dickens, executive director of Springfield City Hospital, Springfield, was named president-elect of the association. Roger Sherman, administrator of Children's Hospital, Akron, was installed as president, succeeding Mr. Foster.

Other officers, all reelected, are: first vice president, John C. Gettman, administrator of Memorial Hospital of Sandusky County, Fremont; second vice president, Sister Eugene Marie, administrator of Good Samaritan Hospital, Cincinnati, and treasurer, Lee S. Lanpher, administrator of Lutheran Hospital, Cleveland. Harry Eader is executive director.

District chairmen of the association are: northeast, Harold A. Zealley, administrator of Elyria Memorial Hospital, Elyria; northwest, Sister Mary Aquin, administrator of St. Rita's Hospital, Lima, and southwest, Lawrence Brett, administrator of Bethesda Hospital, Cincinnati.

Ludell Sauvageot was appointed to the newly created position of hospital auxiliaries counselor for the state of Ohio. Mrs. Sauvageot has been a member of the hospital association's public relations committee for the last four years.

### New Jersey Labor Leaders Oppose Increase in Rates Sought by Blue Cross Plan

TRENTON, N.J.—A public hearing on a request by New Jersey's Blue Cross plan to increase its rates by 28 per cent concluded in five hours here last month, with opposition to the proposed hike from the state A.F.L. and C.I.O. local unions, and the New Jersey Civil Service Association.

Arthur Chapin, state C.I.O. human relations director and a Blue Cross trustee, asked for a state review of hospital rates, saying, "It is the government's responsibility to stop the hospitals from increasing their already exorbitant rates."

Other representatives of labor called for thorough, independent studies of Blue Cross and hospital management, and asked Charles R. Howell, commissioner of banking and insurance, to withhold any rate increase until such studies had been completed.

Paul Krebs, state C.I.O. president, urged "consumer control" of the Blue Cross plan's board of trustees, charging that "domination" of the board by hospital directors is a "major factor in demands for higher rates."

Carl K. Withers, president of the New Jersey Blue Cross plan, said that reserve funds of the plan would be seriously impaired before the end of 1958 unless the rate increase were granted promptly. The proposed increase would bring the reserves up to an estimated \$8 million, or about two months of average claims and operating expense.

### Southern California Council Names Officers

GLENDAL, CALIF.—J. E. Smits, administrator of Children's Hospital, Los Angeles, was named president of the Hospital Council of Southern California at its meeting recently.

Other officers are: vice president, Percy F. Riggs, Hollywood Presbyterian Hospital, Los Angeles; treasurer, William J. Daniels, Hawthorne Community Hospital, Hawthorne, and secretary, Winifred L. Bacon, Hoag Memorial Hospital, Newport Beach.

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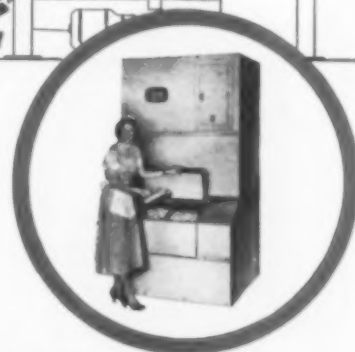
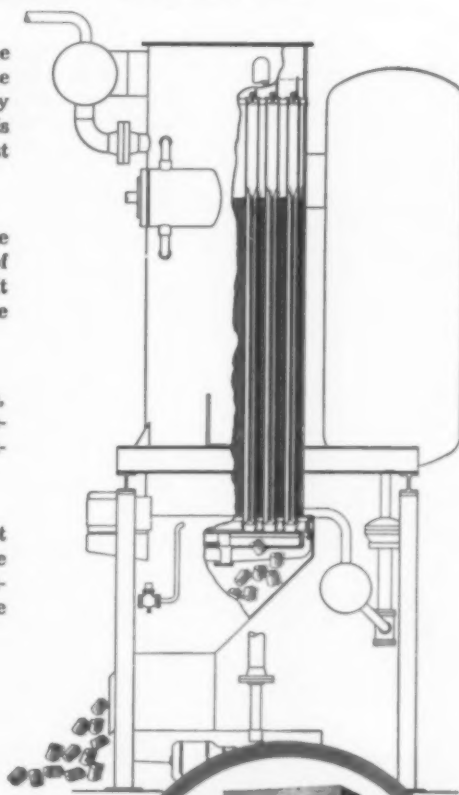
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BETHESDA, CINCINNATI, OHIO	17
CHILDREN'S, AKRON, OHIO	22
CHILDREN'S, BUFFALO, N.Y.	17
CHILDREN'S, PITTSBURGH, PA.	22
DIXIE, HAMPTON, VA.	16
DUKE UNIVERSITY, DURHAM, N.C.	20
A. EINSTEIN MEDICAL CENTER, PHILADELPHIA, PA.	20
EVANSTON, EVANSTON, ILL.	11
FT. BENNING PERMANENT, FT. BENNING, GA.	43
FT. BRAGG, FT. BRAGG, N.C.	43
GLOCKNER-PENROSE, COLORADO SPRINGS, COLO.	27
GOOD SAMARITAN, WEST PALM BEACH, FLA.	16
GRADY MEMORIAL, ATLANTA, GA.	83
McKEESPORT, McKEESPORT, PA.	36
MEMORIAL, SOUTH BEND, IND.	25
METHODIST, ARCADIA, CAL.	15
METHODIST, INDIANAPOLIS, IND.	39
METHODIST OF BROOKLYN, BROOKLYN, N.Y.	17
MOUNT SINAI, MILWAUKEE, WIS.	12
NOTRE DAME, MONTREAL, QUE.	71
OUR LADY OF THE LAKE, BATON ROUGE, LA.	11
PRESBYTERIAN, CHICAGO, ILL.	9
PROVIDENCE, HOLYOKE, MASS.	23
ST. FRANCIS, WICHITA, KA.	33
ST. JOSEPH'S, SOUTH BEND, IND.	22
ST. MARY'S, CENTRALIA, ILL.	12
ST. MICHAEL'S, NEWARK, N.J.	16
ST. VINCENT'S, ERIE, PA.	33
SAN BERNARDINO COMMUNITY, SAN BERNARDINO, CAL.	10
TAMPA MUNICIPAL, TAMPA, FLA.	35
TOLEDO, TOLEDO, OHIO	8
TORONTO GENERAL, TORONTO, ONT.	36
TRINITY, MINOT, N.D.	9
UNIVERSITY OF FLORIDA, GAINESVILLE, FLA.	22
UNIVERSITY OF WASHINGTON, SEATTLE, WASH.	29
U.S. ARMY, FT. DIX, N.J.	43
VETERANS ADMINISTRATION, LONG BEACH, CAL.	34
WADLEY, TEXARKANA, TEX.	11
WESLEY MEMORIAL, WICHITA, KA.	20
WILMINGTON, WILMINGTON, DELA.	15

Lamson Airtube Systems are Lamson designed, engineered, installed. One source — one responsibility. Built for fast, safe, 24-hour operation, day in and day out, with absolute minimum of personnel time required.

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## Candidates for Governor Address 400 Delegates to Alabama Hospital Meeting

TUSCALOOSA, ALA. — Candidates for governor of Alabama all but took over the 37th annual convention of the Alabama Hospital Association here recently when they spoke at the association's annual luncheon and gave their views on state health matters.

The convention was the largest in the history of the group, with more than 400 persons registering. The total would have been greater had civil defense representatives from 28 Alabama counties, present for a session on disaster planning, been counted.

Eight gubernatorial candidates attended the luncheon and three others had representatives to speak for them. Fourteen candidates have qualified for the race for Democratic party nomination for governor.

The invitation by the association to the gubernatorial candidates to appear was another step in its attempt to have the association assume its proper rôle in state health affairs, the associa-



Officers of the Alabama Hospital Association, l. to r.: secretary-treasurer, Ernest S. Williams, assistant administrator, Carraway Methodist Hospital, Birmingham; president, E. E. Cavaleri Jr., administrator, Crippled Children's Clinic and Hospital, Birmingham; president-elect, E. C. Bramlett, the assistant administrator and business manager of the Mobile Infirmary, Mobile.

tion's secretary reported. Also, it gave the group's members the opportunity to hear firsthand the stands of the candidates and to make up their own minds as to the best man to vote for, he commented.

E. E. Cavaleri Jr., administrator of Crippled Children's Clinic and Hospital, Birmingham, took over as president of the association, succeeding J. Frank Bynum, administrator of Gibson Hospital, Enterprise. E. C. Bramlett, assistant administrator and business manager of Mobile Infirmary, Mobile, was named president-elect, and Ernest S. Williams, assistant administrator of Carraway Methodist Hospital, Birmingham, was reelected secretary-treasurer.

(Cont. on Page 124)

**Problem:**

*How to give  
your patients  
a "Get-Well"  
atmosphere*



How much help do your patients get from the surroundings in your hospital? Are they looking at dark, drab, dingy floors that absorb light and dampen spirits? How can you create a "get-well" atmosphere in your patient rooms?

**Solution:**

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Vina-Lux floors can solve your problem. Their soft, clean, attractive colors, quiet resilience, easy-cleaning surface all combine to *lift* the spirits of patients — reduce the fatigue of your staff! Write today for the full Vina-Lux story.

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Colors  
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- MOVE IN LIKE FURNITURE
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When you come to planning patient rooms, either for new construction or re-modelling, remember Maysteel Wardrobe Units offer so much more — in beauty, convenience, sanitation, durability, space-saving and welcome color harmony! Completely self-supporting, they move in like furniture, yet they provide the ultimate in "built-in" architectural unity.

#### Unlimited Design Combinations

In Maysteel's exclusive "Unit Designs" you have opportunity for endless variety in attractive, modern wardrobe arrangements . . . A choice of many wardrobe sections of varying size, capacity, shelf and storage facilities; either vanity or lavatory top; any combination of bases, drawers or doors; several mirror and light designs; overhead storage units . . . All combine as easily as building blocks, and provide for restful "Decorator Color Harmony" that sets each room apart in architectural perfection.



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#### MAYSTEEL CASEWORK

Available in Stainless Steel,  
Decorator Colors, or Combinations.



738 N. Plankinton Ave., Milwaukee 3, Wisconsin  
Representatives in Principal Cities

(Continued From Page 122)

Among the other officers elected by the association: trustees, J. W. Brown Jr., administrator, Russell Hospital, Alexander City; George A. Lerrigo, administrator, Sylacauga Hospital, Sylacauga, and J. Cecil Hamiter, administrator, Baptist Memorial Hospital, Gadsden; delegate to the American Hospital Association House of Delegates, W. B. McGehee, administrator, Stabler Infirmary, Greenville, and alternate delegate to the A.H.A. House of Delegates, J. Frank Bynum.

A feature of the annual luncheon was the presentation of appreciation plaques to the five members of the legislative interim committee on indigent medical care, the group that studied the state's indigent medical care problem and recommended legislation that was subsequently enacted by the 1957 legislature as Alabama's first statewide indigent care law.

Just prior to the luncheon a session was held to discuss the new law. On a panel for that purpose were State Sen. Albert Boutwell of Birmingham; Rep. R. G. Kendall Jr. of Evergreen, who was chairman of the interim group; Dr. D. G. Gill, state health officer, and Dr. Ira L. Myers, administrative officer of the state public health department, the agency administering the program.

In the disaster planning session, members heard Paul R. Brunson, assistant director of the state civil defense department, speak on "Disaster Can Happen Here," and a panel discussion on the various phases of civil defense. The panel was moderated by Dr. William J. McNally, medical officer for Region 3, Federal Civil Defense Administration, Thomasville, Ga. A part of the disaster planning program was the display of elements of a 200 bed emergency hospital set up on the grounds of the headquarters hotel.

Also appearing on the convention program were American Hospital Association President Tol Terrell, A.H.A. Deputy Director Maurice J. Norby, Frank S. Groner, president, American College of Hospital Administrators, and James E. Stuart, executive vice president of the Blue Cross Association.

During its annual business meeting the association adopted a revised set of by-laws designed to modernize the group's basic structure. Also, the association's central office was instructed to compile statistics to show how hospitals rank in size in the state's business fields, and to disseminate this information to news media and other interested groups.

Time and place of the association's 1959 annual meeting are to be determined.

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#### ALCONOX

For all equipment washed  
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Box of 3 lbs.	\$1.95
Case of 12 boxes—3 lb. ea.	\$18.00
Drum of 25 lbs.	.45 lb.
Drum of 50 lbs.	.42 lb.
Drum of 100 lbs.	.40 lb.
Drum of 300 lbs.	.37 lb.

(Slightly higher West of  
Rockies)



#### ALCOJET

For all equipment washed  
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Case of 6 boxes—5 lb. ea.	\$15.00
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Drum 300 lb.	.37 lb.

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Rockies)



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For cleaning all pipettes in  
one easy operation

Box 100 tablets	\$5.00
Case of 6 boxes of 100 tablets	\$30.00

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or write for literature and sampler.

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*Now* ...a Better Technique  
for Patient Utensils

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**UTENSIL WASHER  
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**T**he American Utensil Washer-Sanitizer provides efficient equipment to carry out an improved technique in preventing the transfer of communicable diseases among patients and hospital personnel. Convenient and automatic, it washes and sanitizes three full sets of patients' utensils in two loads . . . at a speed well within the normal discharge-and-admission rate. Simple and economical to install and operate, the Washer-Sanitizer saves personnel time, reduces utility room clutter and assures uniform cleaning and sanitizing at less cost.

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• The American Utensil Washer-Sanitizer is available with stainless steel utility room clean-up counter or as the free-standing unit shown above.



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## G. P. Academy Seeks Action Penalizing Hospitals Which Exclude or Discriminate Against G. P.'s

DALLAS, TEX.—Hospitals which exclude or discriminate against general practitioners should be denied accreditation, the American Academy of General Practice said here last month in a report presented to the academy's congress of delegates by the commission on hospitals.

General hospitals are the medical centers of any community and "have an obligation to provide medical care facilities for the use of every licensed physician," the report said.

It was presented to the congress of delegates at the 10th annual meeting of the academy here last month, attended by 5000 family doctors.

Teamwork in the care of patients can only be accomplished when the family doctor and specialist work together at the hospital, the report indicated. "This objective can be attained only by abandoning arbitrary restrictions and opening hospital doors to all qualified practicing physicians," it said.

Some hospitals are classified as general community hospitals but staffed almost entirely by specialists, it was pointed out. "The family doctor is thus often denied hospital facilities and required to turn his patients over to a team of staff specialists," the commission stated.

The problem of hospital privileges for general practitioners is not widespread, it was indicated. "In most communities, the credentials committee places the emphasis on individual consideration of the applicant's training and experience," the commission report said. "However, reports reaching the academy indicate that general hospitals in some areas have revised their rules and regulations and are now restricting family doctors. Members of the commission feel that such hospitals should be asked to stop discriminating and, if they don't comply, should not be accredited."

The commission does not insist that the doctor who has completed a one-year internship can request full hospital privileges and expect immediate approval, the report said. Instead, it contends that privileges and restrictions be based on "thorough study of the qualifications presented by each applicant and not solely on a certificate indicating that certain specialty group requirements have been met."

In a report to the delegates, Mac F. Cahal, executive secretary of the academy, said the tendency of hospitals to restrict general practitioners arbitrarily in their privileges or exclude them from staff appointments had been "largely overcome."

"Our problem today is not the same as it was 10 years ago, when actual exclusion was the threat," Mr. Cahal said. "Rather it is the need to achieve uniform agreement concerning basic privileges embraced in general practice."

Other goals of the academy that have been accomplished are improved orientation for general practice in undergraduate medical education and establishment of general practice residencies for graduate training, Mr. Cahal reported.

## California Conference Elects New Officers

BURLINGAME, CALIF.—Ray Grove of Monterey Hospital, Salinas, is the new president-elect of the California Central Coast Hospital Conference.

Other officers are: president, Richard Blaisdell, administrator of Peninsula Hospital, Burlingame, and secretary, Bruce Sanderson, assistant director of Palo Alto Hospital, Palo Alto. Dr. Harvey E. Robins, administrator of Santa Cruz County Hospital, Santa Cruz, is immediate past president.



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For geriatrics cases . . . prone position patients . . . leg amputees . . . post operatives . . . Porto-Lift meets every lifting need easily, in complete safety and comfort.

Have your nearest medical supply dealer demonstrate a Porto-Lift for you, or write Dept. K, Porto-Lift Manufacturing Company.

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# "GOLDEN VILLAIN"

AS THE JANUARY 1958 READER'S DIGEST CALLS  
STAPHYLOCOCCUS AUREUS



## succumbs to Wescodyne's detergent-germicide action



Air-borne bacteria that contain "Staph" and other organisms can be controlled by cleanup procedures with WESCODYNE, the first "Tamed Iodine"® Detergent-Germicide. A simple one step application kills staph germs quickly while removing soil and dust.

WESCODYNE is the single hospital germicide suitable for all disinfecting and sterilization procedures. It is nonselective. Destroys T.B., Polio, other viruses, bacteria, spores, fungi. This wide-spectrum biocidal activity offers a greater range of effectiveness than solutions containing chlorine, cresylics, phenolics or quaternaries.

WESCODYNE increases germicidal capacity to three to four times that of other germicides — as tested on successive kills of seven common organisms. It is nonstaining, nonirritating, nontoxic. Leaves no odor. Saves time and labor because it cleans as it disinfects.

WESCODYNE costs less than 2¢ a gallon at the general-purpose use dilution of 75 ppm available iodine. Sound worthwhile? Send the coupon for full information, including recommended O.R., housekeeping and nursing procedures.

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## Hospitals Must Intensify Clinical Research and Education, Harris Says

CHICAGO.—It is up to the nation's major hospitals to lead the way in giving their patients the full benefit of medicine's rapidly advancing knowledge by intensifying patient-centered programs of clinical research and education, Irving B. Harris, the newly elected president of Michael Reese Hospital Medical Center, Chicago, said recently.

"We know that we must even more actively seek out and develop tomorrow's medical leaders. We must give them the research funds, and educational opportunities, and intellectual freedom to lead the world to new medical discoveries, train the new generation of scientist-physicians, and, above all, to bring their medical knowledge to bear on man's ills," Mr. Harris said.

In 1958, Mr. Harris said, Michael Reese will move ahead on the following series of projects at a total cost of \$5,300,000:

1. A new department of experimental surgery will be set up. The hospital is now seeking an outstanding young

surgeon to head this department of the Medical Research Institute.

2. Expenditure for research in 1958 has been increased to \$781,000, compared to a research budget in 1952 of \$543,000.

3. The number of physicians employed full time by the medical center is also increasing steadily, from 37 as of five years ago to 50 today. Future programming calls for a number of additional full-time men, to aid the 550 doctors on the medical staff who volunteer in the research and educational fields.

4. In the field of medical education, in 1958 the medical center has budgeted a total of \$412,000 for the teaching of residents and interns, compared to the \$176,000 which was spent in 1952.

5. Plans are being drawn for a two-story surgical wing for the M. S. Kaplan pavilion, to house expanded operating rooms and laboratories at an estimated cost of \$2,200,000.

6. Now under construction is the \$1,200,000 five-story Ruth Cummings Research Pavilion, to be completed in January 1959. This new building will give scientists more adequate space in which to carry on their investigations.

7. A major rehabilitation of the Nelson Morris Research Building is being planned, at a cost of \$600,000.

8. A full-time physician, Dr. Herbert Rubenstein, has been appointed to head the intern teaching program, as assistant director of medical education.

9. One of the most pressing needs is to retain promising young doctors in the research and educational programs after they have completed their formal residency training. There is no government or foundation financing available for this purpose. Michael Reese is establishing at least six clinical research fellowships to meet this need.



## THE JEWETT AUTOPSY TABLE

The Jewett Autopsy Table is recommended by pathologists in all parts of the country. All stainless steel sanitary construction, adjustable rests and supports for any size body, movable instrument tray, choice of head rests, ease and convenience of dissection ... these are just a few of its outstanding features. This table was actually designed by practicing pathologists and incorporates ideas from several leading members of the medical profession. Your first experience with the Jewett Autopsy Table will demonstrate that it was built to meet your requirements.

*We also invite your inquiry on custom-designed equipment.*

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MANUFACTURERS  
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FOR INSTITUTIONS  
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**REFRIGERATOR  
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## Sloan Institute Plans Three Summer Seminars

ITHACA, N.Y.—Hospital administrators and related executives are eligible on a fellowship basis to attend the first hospital administrators' development program to be held at Ithaca, N.Y., by the Sloan Institute of Hospital Administration of the Cornell University Graduate School of Business and Public Administration under a grant from the Alfred P. Sloan Foundation, school officials have announced. Three seminars of two weeks each will be held during the period July 7 to August 15, 1958. The subjects to be covered are medical care, administration and hospital interpersonal relationships.



## *New Hill-Rom All-Electric ("Push-Button") Hilow Bed*

● This modern, safe and efficient hilow hospital bed saves much time for the nurse by eliminating unnecessary trips to the patient room or unit. The patient has access to the head and knee rests and does not need the nurse for routine adjustment of the spring. If the patient's position is not to be changed, the nurse can flip the cutout switch for the head rest or knee rest—or both—making the push-button controls inoperative. Only one motor unit does the entire work of operating this all-electric bed. Fully approved by the Underwriters' Laboratories as safe for use with oxygen.

Head and footboard panels, designed by Raymond Loewy, are covered with Teakwood grain Farlite, a pressure laminated plastic which is im-

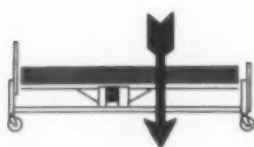
pervious to alcohol, iodine and other ordinary chemicals used at the bedside, and is also heat resistant. Also available in other woods and finishes. A satin-finish stainless steel band protects the top sides and bottom of the panels. Cut outs in center of headboard for cervical traction, and on the sides and head of the footboard for lateral frames.

Procedure Manual No. 3, by Alice L. Price, R.N., M.A., explaining the correct usage of Hilow beds, is available for student and graduate nurses.

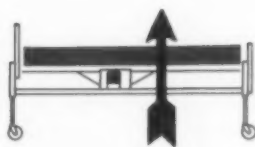
*(For further information on this new push-button Hilow bed, see other side of this page.)*

**HILL-ROM COMPANY, INC. • BATESVILLE, INDIANA**

**ANY HEIGHT . . . ANY POSITION . . . AT THE TOUCH OF A BUTTON**



\* low position



\* high position



\* head rest



\* knee rest



*Safety sides do not interfere with use of the patient control panel.*

**ANY HEIGHT—ANY SPRING POSITION  
AT THE TOUCH OF A BUTTON—  
BY EITHER PATIENT OR NURSE**

● This all-new, all-electric "push button" Hill-Rom Hilow bed sets an entirely new standard for convenience, utility and patient comfort, and is the last word in adjustable height bed design and performance. It is designed so that operation of the Hilow feature and adjustment of the backrest and kneerest may be handled by the patient. As shown above, push button controls for patient use are located on the patient's right—in the seat section of the spring. If such patient operation is undesirable, the nurse can easily make it impossible by the use of "cut-out" switches on the motor unit. All switches are mechanically interlocked—no two push buttons can be operated at the same time. Head end and foot end panels are designed by Raymond Loewy.

With the addition of this new "push-button" model Hill-Rom now offers *four* different hilow beds, including both manually and electrically operated models. Complete information on any of these hilow beds will be furnished on request.

**HILL-ROM COMPANY, INC., Batesville, Ind.**



*The nurse also finds the push button control panel is conveniently located.*



**NOW READY!  
PROCEDURE MANUAL No. 3**

**Hilow Beds** is the subject of Procedure Manual No. 3, prepared by Alice L. Price, R.N., M.A., Nurse Consultant for Hill-Rom Co., Inc. and author of three leading textbooks on nursing—*The American Nurses Dictionary*, *A Handbook for Student Nurses* and *The Art, Science and Spirit of Nursing*. Copies for student nurses and graduate nurse staff will be sent on request. Address Miss Alice L. Price, Hill-Rom Co., Inc., Batesville, Ind.

## COMING EVENTS

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Institutes: 8th New York, New York, June 23-27; 8th Western, Palo Alto, Calif., June 23-27; 26th Chicago, University of Chicago, Sept. 2-12; 9th Chicago Advanced, University of Chicago, Sept. 8-12.

AMERICAN COLLEGE OF HOSPITAL ADMINISTRATORS, Members Conferences: Regions 17, 18, Montreal, Que., April 14-18; Region 11, Kansas City, Mo., Oct. 20-24; Region 10, Minneapolis, Oct. 27-31; Region 1, Boston, Nov. 10-14; Region 8, East Lansing, Mich., Nov. 17-21.

AMERICAN DIETETIC ASSOCIATION, Bellevue Stratford and Benjamin Franklin Hotels, Philadelphia, Oct. 21-24.

AMERICAN HOSPITAL ASSOCIATION, convention, Palmer House, International Amphitheater, Chicago, Aug. 18-21.

AMERICAN OSTEOPATHIC HOSPITAL ASSOCIATION, Statler Hotel, Boston, Oct. 26-29.

AMERICAN SOCIETY OF MEDICAL TECHNOLOGISTS, Schroeder Hotel, Milwaukee, June 15-20.

ARKANSAS HOSPITAL ASSOCIATION, Arlington Hotel, Hot Springs, May.

ASSOCIATION OF OPERATING ROOM NURSES, Bellevue-Stratford Hotel, Philadelphia, Feb. 10-12.

ASSOCIATION OF WESTERN HOSPITALS, Civic Auditorium, San Francisco, April 21-24.

BRITISH COLUMBIA HOSPITALS' ASSOCIATION, Hotel Vancouver, Vancouver, Oct. 28-31.

CALIFORNIA HOSPITAL ASSOCIATION, Biltmore and Miramar Hotels, Santa Barbara, Oct. 22-24.

CAROLINAS-VIRGINIAS HOSPITAL CONFERENCE, Hotel Roanoke, Roanoke, Va., April 24, 25.

CATHOLIC HOSPITAL ASSOCIATION, Atlantic City, N.J., June 21-26.

COMITÉ DES HÔPITAUX DU QUÉBEC, Montreal Show Mart, Montreal, Que., June 25-27.

CONNECTICUT HOSPITAL ASSOCIATION, Berlin Light and Power Co., Berlin, June 11.

HOSPITAL ASSOCIATION OF NEW YORK STATE, Hotel Claridge, Atlantic City, May 21-23.

HOSPITAL ASSOCIATION OF PENNSYLVANIA, Convention Hall, Atlantic City, May 21-23.

IDAHO HOSPITAL ASSOCIATION, Elks Temple, Boise, Oct. 20, 21.

INDIANA HOSPITAL ASSOCIATION, Indiana Student Union Building, Indianapolis, Oct. 8, 9.

IOWA HOSPITAL ASSOCIATION, Savary Hotel, Des Moines, April 24, 25.

KANSAS HOSPITAL ASSOCIATION, Baker Hotel, Hutchinson, Nov. 13, 14.

KENTUCKY HOSPITAL ASSOCIATION, Sheraton-Seelbach Hotel, Louisville, April 15-17.

MAINE HOSPITAL ASSOCIATION, Sameset Hotel, Rockland, June 10, 11.

MARYLAND-DISTRICT OF COLUMBIA-DELAWARE HOSPITAL ASSOCIATION, Shoreham Hotel, Washington, D.C., Nov. 3-5.

MASSACHUSETTS HOSPITAL ASSOCIATION, Hotel Statler, Boston, May 15.

MICHIGAN HOSPITAL ASSOCIATION, Grand Hotel, Mackinac Island, June 17, 18.

MIDDLE ATLANTIC HOSPITAL ASSEMBLY, Convention Hall, Atlantic City, N.J., May 21-23.

MINNESOTA HOSPITAL ASSOCIATION, Lowry Hotel, St. Paul, Nov. 7.

MISSISSIPPI HOSPITAL ASSOCIATION, Hotel Heidelberg, Jackson, Oct. 23, 24.

MISSOURI HOSPITAL ASSOCIATION, President Hotel, Kansas City, Nov. 19-21.

MONTANA HOSPITAL ASSOCIATION, Havre, Sept. 15, 16.

NATIONAL ASSOCIATION FOR PRACTICAL NURSE EDUCATION, Hotel del Coronado, Coronado, Calif., April 14-18.

NATIONAL GERIATRICS SOCIETY, 5th annual convention and exposition, Henry Hudson Hotel, New York, May 13-15.

NEBRASKA HOSPITAL ASSOCIATION, Omaha, Oct. 23, 24.

NEW ENGLAND HOSPITAL ASSEMBLY, Institute on Housekeeping in Hospitals, Hotel Statler, Somerset, Boston, April 21-25.

NEW JERSEY HOSPITAL ASSOCIATION, Convention Hall, Atlantic City, May 21-23.

NORTH DAKOTA HOSPITAL ASSOCIATION, Gardner Hotel, Fargo, April 22, 23.

OKLAHOMA HOSPITAL ASSOCIATION, Skirvin Hotel, Oklahoma City, Nov. 6, 7.

OREGON ASSOCIATION OF HOSPITALS, Oct. 13, 14.

SOUTH DAKOTA HOSPITAL ASSOCIATION, Marvin Hughitt Hotel, Huron, April 7, 8.

SOUTHEASTERN HOSPITAL CONFERENCE, Hotel Fontainebleau, Miami Beach, Fla., May 14-16.

TEXAS HOSPITAL ASSOCIATION, Statler-Hilton Hotel, Dallas, May 5-8.

TRI-STATE HOSPITAL ASSEMBLY, Palmer House, Chicago, April 28-30.

UPPER MIDWEST HOSPITAL CONFERENCE, Minneapolis Auditorium and Leamington Hotel, Minneapolis, May 14-16.

VIRGINIA HOSPITAL ASSOCIATION, Hotel Roanoke, Roanoke, Nov. 14-16.

WASHINGTON STATE HOSPITAL ASSOCIATION, Winthrop Hotel, Tacoma, Oct. 15, 16.

WEST VIRGINIA HOSPITAL ASSOCIATION, Daniel Boone Hotel, Charleston, Oct. 15-18.

## 1958 HOSPITAL CAMPAIGN EXCEEDS GOAL BY 31%



Bucyrus Community Hospital, Bucyrus, Ohio  
Goal: \$650,000 Pledged: \$852,000

### *Ketchum, Inc. directs most successful campaign in history of Bucyrus, Ohio*

In a community-wide campaign just completed, the Bucyrus Community Hospital, Bucyrus, Ohio has gone over its building fund goal by 31%. The campaign raised a total of \$852,000 for a new hospital wing—an amazing response for a hospital in a service area of about 12,000 persons.

If your hospital is planning a fund-raising campaign, get in touch with Ketchum, Inc. right away. Professional planning and direction are essential to success. The earlier we start working with you, the more help we can be.



## KETCHUM, INC.

### *Direction of Fund-Raising Campaigns*

CHAMBER OF COMMERCE BUILDING  
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500 FIFTH AVENUE, NEW YORK 36, N. Y.  
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## Strikers Picket Swedish Hospital in Seattle

(Continued From Insert Op. 49)

through the picket line on the second day of the strike only after there had been a 15 minute delay, and police had been called to prevent disorder.

Hooper said an effort would be made to halt deliveries of fuel oil, normally made twice a week. Oil is burned in the boilers supplying steam.

Some garbage collections were halted.

With no steam available in the laundry, some laundry was done the first day by commercial laundries. Beginning the first day, and continuing thereafter, facilities in two other Seattle hospitals were used for Swedish Hospital laundry.

Laundry employees are members of another union. No effort has been made to keep them from crossing picket lines. Laundry was hauled to other hospitals in a drive-yourself truck rented by the hospital and kept on the premises.

The hospital closed its employees' cafeteria. Another hospital, eight blocks away, provided meals for the house staff and student nurses. The cafeteria provided a few cold meals while leftover food was on hand.

Raymond F. Farwell, administrator, said, although the hospital never re-

ceived formal or written notice a strike was to be called, a build-up of supplies had begun a week before the expected deadline. An attempt was made to bring stores of nonperishable items to capacity, without obviously large deliveries at any one time.

A few additional employees were hired the day before the strike. Fuel oil was topped off the night before, two days ahead of usual delivery time.

After the strike began, the hospital was "swamped," Farwell said, with offers of assistance from former employees, volunteers and others. So many applicants for work appeared, the personnel office overflowed. By the second day of the strike, 30 new workers had been employed.

Eleven dietitians were on duty in the kitchen, compared with the usual seven, from the first meal after the strike began.

The union claimed 120 hospital employees were participating in the strike. Farwell said not more than 75 were absent of the 300 in the categories in which the union claims jurisdiction. There are 1000 employees in all categories in the hospital.

The strike was sanctioned by the King County Central Labor Council the night before the picketing began. Previously, hospital representatives had met with the council to explain their position.

Farwell said the hospital had agreed to recognize the union only when it represents a majority of workers in its categories in all hospitals belonging to the Seattle Hospital Council.

"As far as I am concerned, this is an outlaw strike," said Farwell. "I will not meet with the union at all as long as the picketing continues."

Farwell added: "We are members of the Seattle Hospital Council, which speaks for us on labor-relations matters. We consider this dispute an industry-wide matter."

"We also are proud that our employees traditionally have received as high or higher pay than have those of similar skills in other private hospitals of the city."

Dr. James E. Hunter, president of the hospital council, said a policy has been in effect since 1938 of not recognizing any union unless it represents a majority of all appropriate employees in the city.

One 200 bed member of the council, Virginia Mason Hospital, signed an agreement with the union last year, however, after long and bitter negotiations. The union struck Virginia Mason Hospital in 1946, the last previous hospital strike in Seattle. Group Health Hospital, a council member, and the 750 bed King County Hospital System, had recognized the union previously. (Cont. on Next Page)

## On our floor

THIS IS THE WAY I LIKE TO PREPARE AN ENEMA. JUST CALL CENTRAL SUPPLY AND ASK FOR TRAVAD.

YOU'RE SO RIGHT. THE TRAVAD DISPOSABLE ENEMA IS A BOON TO BUSY HOSPITALS. ... AND IT'S EQUIVALENT TO 1500 cc. OF SOAP SOLUTION.

HANDLING ENEMA REQUISITIONS IS A CINCH NOW. TRAVAD SURE EASES THE WORK LOAD FOR US.



**TRAVENOL LABORATORIES, INC. Morton Grove, Illinois**

(Continued From Page 130)

Picketing at Swedish Hospital has continued on a 24 hour basis, with eight to ten placarded pickets, many of them women, on duty at a time. Some union members from other hospitals have been on the picket lines.

Farwell was given his only direct notice of the impending strike late the afternoon before in a telephone call from Arthur T. Hare, an international officer of the Building Service Workers' Union, who is the chief union strategist in the dispute.

Hare advised Farwell: "We are going to empty your hospital."

A newspaper reporter informed Farwell at his home at 10 o'clock that night that the Labor Council had sanctioned the strike. Hooper previously had been quoted in newspapers as saying picketing would begin at various hours after midnight Wednesday. His statements had permitted the hospital to make preparations for the strike.

A week earlier, Hooper had mailed notices to 95 doctors on the hospital staff, informing them of the impending strike and urging them not to admit patients who would be in the hospital after the March 20 deadline. Farwell said as far as he could determine no doctor complied. The hospital has 250 physicians regularly admitting patients to the hospital.

### Xavier University Plans "Grass-Roots" Courses in Hospital Administration

CINCINNATI.—New graduate and undergraduate courses in hospital administration, designed to assist in the professional development of hospital personnel, will be started this summer by Xavier University, it was announced last month.

The undergraduate study, which will comprise 15 credit hours taken in five workshops, is planned for hospital employees who want college credit but who have not completed requirements for a bachelor's degree. Subjects will include personnel administration, financial management, insurance, purchasing, public relations, fund raising, hospital law, food service, maintenance and social problems. The first workshop will be held on the campus from August 4 to 16.

The graduate program, opening June 16, is designed for students working for a master's degree in business administration with a concentration on hospital administration. Fifteen credit hours in hospital administration and at least 15 hours in four core courses of business administration will be required.

"The university does not plan at the present time to offer the master's degree in hospital administration, in-

asmuch as the need is at the 'grass-roots' level," said James F. Martin, assistant professor of business administration and coordinator of the new Xavier program.

### Chicago Area Organizes Hospital Planning Council

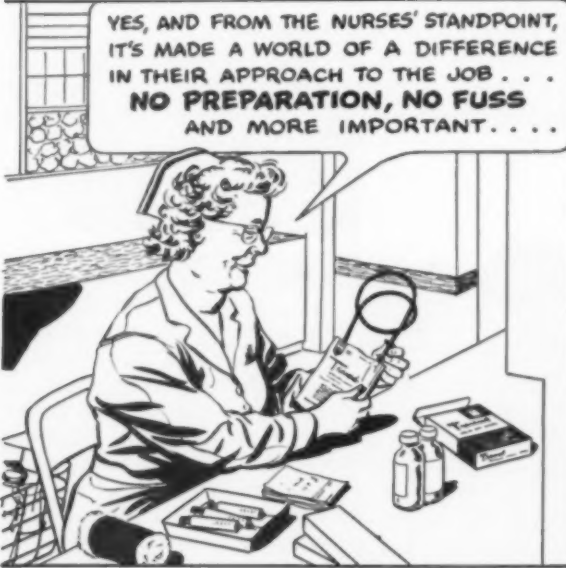
CHICAGO.—The Hospital Planning Council for Metropolitan Chicago was formed here last month as a step toward solution of the Chicago area's growing need for hospital facilities.

Objectives of the new council are to: plan the efficient and economical development of hospitals in accordance with needs and available resources and review proposals of individual hospitals for major capital expenditures; coordinate the services of hospitals and public health and welfare agencies; recommend standards and ways to improve services and financial economy of hospitals; provide a means for closer correlation of the interests of hospitals and the medical profession; advise the public of financial needs of hospitals, and interpret to the community the services available for care of the sick.


Business and civic leaders head the new council, together with representatives of hospitals and welfare agencies.

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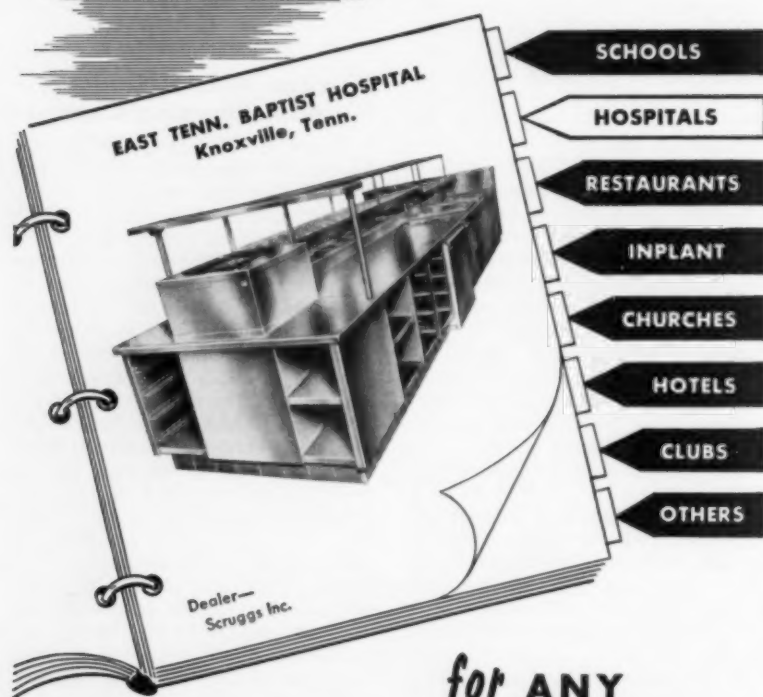


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## Columbia's Correspondence Course Open to Candidates From All Over Country

NEW YORK.—Hospital administrators from throughout the United States are now eligible for the basic hospital administration correspondence course conducted by Columbia University's Program of Continuation Education, it was announced here recently. The course has formerly been open to applicants from the New England or Mid-Atlantic areas only.

The applicant attends an on-campus session at the university from May 26 to June 6, 1958, followed by an 11 month home study program involving a lesson per month. The course is climaxed by a final two-week on-campus session scheduled for June 1959.

Study encompasses five major areas: (1) the purpose and function of a hospital as a center of the community's medical services, (2) the several methods of operating departments in the hospital, (3) the various services offered by each department, (4) the alternative methods of organizing a hospital, and (5) management problems faced by hospital administrators.

The applicant, who must be the administrator or chief executive officer of a hospital of 125 beds or less, should have a high school diploma but cannot have an advanced degree in hospital administration.

## MICHIGAN PLAN HIRES "BRAIN"



An employee of Michigan Blue Cross-Blue Shield, Detroit, activates the new 40 ton computer the hospital service has hired to handle its paperwork. The "brain" will keep track of the records of 3½ million subscribers and can handle an average of 25,000 daily record changes within two hours. Any member's record, or any part of it, can be located and reported on in less than two minutes. The new system reduces the amount of floor space required for record storage to a single cabinet occupying less than 6 square feet. The 24 section brain, which is rented for \$37,000 per month, is housed in 5000 square feet of space.

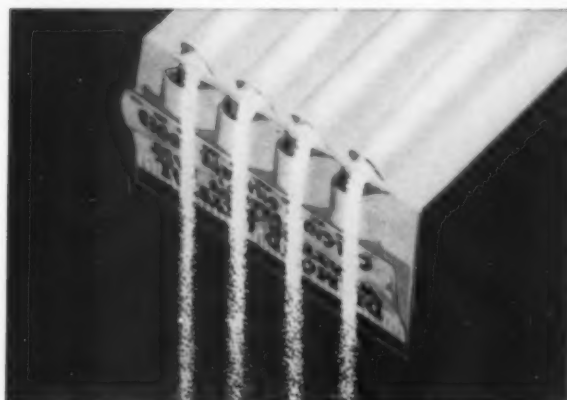
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Your hospital is assured of electric power at all times with Onan Emergency Electricity. Operation is completely automatic. When highline power is interrupted, the plant starts automatically; stops when power is restored.

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## Tennessee Association Names Frank Magoffin as New President-Elect

CHATTANOOGA, TENN.—Frank Magoffin, administrator of Oakville Memorial Sanatorium, Memphis, was named president-elect of the Tennessee Hospital Association at its annual meeting held here March 13 to 15. William B. Barnhart, administrator, Maury County Hospital, Columbia, took office as president.

Other officers elected for the coming year are: first vice president, Charles W. Holmes, administrator, Campbell Clinic-Hospital, Memphis; second vice president, Dr. Richard O. Cannon, director, Vanderbilt University Hospital, Nashville; treasurer, Gene Kidd, administrator, Baptist Hospital, Nashville (reelected). Trustees are Robert F. Scates, assistant administrator, Baptist Memorial Hospital, Memphis (three years); William L. Simon, administrator, Baptist Hospital, Knoxville (three years), and Stacy Johnson, administrator, Memorial Hospital, Clarksville (one year).

## Telephone Company Asks "Open Door" Policy in Hospitals Seeking Funds

CHICAGO.—The Illinois Bell Telephone Company, one of the largest contributors to hospitals in the Chicago area, announced last month that hospitals asking the company for funds must admit patients of all races.

An official of the company said: "We want to make sure that all our employees are benefiting by our donations. This is no more than is required by state law and city ordinance. This is the first time we have asked whether the admissions policy is restricted as to race, creed or color.

"From now on this question will be a regular part of our procedure when hospitals approach us for building fund contributions. . . . We take the answer into consideration when deciding what action to take."

## Pennsylvania Purchasing Group Reelects Officers

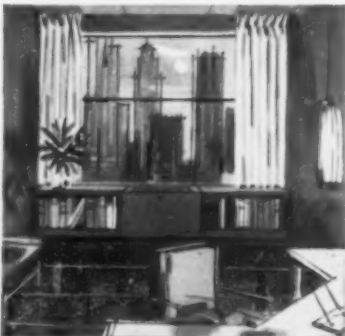
PHILADELPHIA.—Melvin L. Sutley, administrator of Wills Eye Hospital, Philadelphia, has been reelected president of the Hospital Purchasing Service of Pennsylvania. Also reelected at the group's 10th annual meeting recently were: vice president, W. W. Frazier III of St. Christopher's Hospital, Philadelphia; secretary, C. Rufus Rorem, executive director of the Hospital Council of Philadelphia, and treasurer, Dr. Lucius R. Wilson, administrator of Episcopal Hospital, Philadelphia.

## York fan coil units adapt to any interior design

These attractive room treatments are just a few of the many possible with these versatile units. Whether free-standing, free-hanging or furred-in models are selected, you'll find your interior design problems simplified by their compactness and modest water and power-supply requirements.



Free standing unit with decorative casing suits many requirements.



Wall-hung unit with wall-to-wall bookcases is both attractive and functional.



Furred-in ceiling unit solves space problems . . . keeps floor-space productive.

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**THE CHOICE IS WIDER!** York is the only manufacturer offering a choice of floor, wall, and ceiling-mounted units. There are 20 models to choose from—the longest line in the air conditioning industry.

**THE QUALITY'S UNMATCHED!** Every model is UL-approved. Few competitive units offer this assurance of trouble-free performance. Permanent split-capacitor motors are standard in York fan coil units. They cut power consumption by as much as 40%, require fewer electrical circuits—and, because they run slower and cooler, have a 30% greater life expectancy. There is no exposed wiring; flexible steel conduit is used throughout.

**THE PRICE IS RIGHT!** From the moment York fan coil units arrive on site, they start saving money. That's because York designs with the *real cost* of air-conditioning in mind. The features listed above are just a few of the many you'll want explained in detail. Consult your classified directory for the name and address of your local York sales representative . . . or write for Bulletin I-216. York Corporation, York, Pa.

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Hyland Antihemophilic Plasma is irradiated, dried, and supplied with diluent. In 3 sizes: 50 cc. with built-in filter for syringe administration; 100 and 250 cc., each with complete plasma administration set, including small-gauge I.V. needle to minimize vein trauma.

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Colors stay daisy fresh. Can't chip nor peel—unaffected by alcohol or disinfectant.



B-34 CS Jumbo 34 qt. basket with easy on and off cover. 19 high.

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in your choice of round, oval or rectangular styles in capacities from 7½ quarts to over 8 gallons. 5 models with feet, also with covers for hampers or odor-free sanitary containers. Colors to meet your decorating needs. Order from your supplier or write for catalog and information. Nationally advertised values GUARANTEED by COLUMBUS PLASTIC PRODUCTS, INC., Columbus, Ohio.

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## Periodic Evaluation of Laboratory Tests Urged

RICHMOND, VA.—The accuracy of hospital laboratory tests can be improved if the tests are evaluated periodically, Virginia pathologists and medical technologists were told here last month.

Speaking before the fifth annual meeting of the two state societies, Dr. William D. Dolan of Arlington Hospital, Arlington, described the surveys made over a period of five years by 21 laboratories in the Washington, D.C., area to check the accuracy of their hemoglobin tests. Each survey, he said, resulted in adoption of changes in standards of reference, procedures and technics. As a result, in the latest survey, 80 per cent of the hemoglobin tests performed in laboratories supervised by pathologists were found to vary only in slight degree, and none varied to a clinically significant degree.

## New Gas for Sterilization in Hospitals Is Announced

JERSEY CITY, N.J.—Discovery of a new bactericidal gas that may prove to have many applications in hospital sterilizing technics was announced here recently.

The new gas, beta-propiolactone, was described by C. R. Phillips, chief of the physical defense division of the army chemical corps, Fort Detrick, Md. His paper was delivered at Seton Hall College of Medicine and Dentistry as part of the Becton, Dickinson lectures, a series on sterilization technics sponsored by the medical supply firm and the college.

The compound had been used previously for sterilization, but only in aqueous solution, it was reported. As a gas, it acts as effectively as formaldehyde vapor but works more rapidly and with fewer adverse side effects. Mr. Phillips predicted that the gas will prove to have "important applications" with possible use in sterilizing operating rooms and nurseries.

## Chicago Opens Hospital for County Jail Inmates

CHICAGO.—A 50 bed hospital for prisoners at the Cook County jail, built at a cost of \$25,000, was opened here recently. In a county bond issue last spring, \$260,000 was voted for building the hospital, but this money remains untouched. Instead, the hospital was built with funds from regular maintenance accounts and with labor volunteered by maintenance men.

Facilities include an isolation ward for tuberculous patients, a general ward, and various services.

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## ABOUT PEOPLE

(Continued From Page 76)

**Dr. Paul L. Wermer** has been appointed executive medical director of City of Hope Medical Center, Duarte, Calif. For the last three years, Dr. Wermer has been vice president and medical director of a pharmaceutical company division in New Jersey. Prior to that post, he was associated with the American Medical Association as secretary of various committees and as assistant secretary of the council on

pharmacy and chemistry. He also served in the Public Health Service and was medical administrator of the City of Chicago Clinics.

**Anthony J. Monaco**, administrative resident at Harrisburg Polyclinic Hospital, Harrisburg, Pa., has been appointed administrator of Berwick Hospital, Berwick, Pa., succeeding **Helen Dumack**. Mr. Monaco is a graduate of the hospital administration program at the University of Pittsburgh.

**Arthur E. Miller**, assistant administrator of San Jose Hospital, San Jose, Calif., has been appointed assistant

director of Salt Lake County General Hospital, Salt Lake City, Utah, succeeding **John O. Yale**. Mr. Miller received his master's degree in hospital administration from the University of Minnesota.

**Sister Mary James**, formerly operating room supervisor, has been named assistant administrator of St. Paul's Hospital, Dallas, Tex.

**William A. Stoppani** has been appointed assistant administrator of Carney Hospital, Boston. Mr. Stoppani, a graduate of the course in hospital administration at Columbia University, formerly was assistant administrator of Symmes Arlington Hospital, Arlington, Mass.

**Col. Ernest T. Sheen**, a retired veteran of more than 30 years active service in the Medical Service Corps, U.S. Army, has been appointed administrator of the Pomona Valley Community Hospital, Pomona, Calif. He is a graduate of the program in hospital administration of the Medical College of Virginia at Richmond.

**Ned W. Wickham**, former administrator of Huntsville Hospital, Huntsville, Ala., and recently administrator of Miller Clinic, Nashville, Tenn., has been named administrator of D. W. McMillan Hospital, Brewton, Ala. He succeeds **Robert H. Boone**, who resigned to become administrator of Fayette County Hospital, now under construction at Fayette, Ala.

**Floyd H. Wachter** has been appointed acting superintendent of Community Hospital, Wickenburg, Ariz., succeeding **L. B. Bramkamp**. Mr. Wachter was superintendent of the former Community Hospital from 1946 to 1953. A new plant was completed last spring.

**E. Y. Ashcraft**, assistant administrator of Coahoma County Hospital, Clarksdale, Miss., has resigned to join the hospital and physicians relations department of Louisiana Hospital Service, Baton Rouge.

**Marta Maples** has succeeded **Robert A. Wall** as administrator of Greene County Hospital, Leakesville, Miss.

**Clifford Bass** has been named administrator of Jefferson Davis Memorial Hospital, Prentiss, Miss., succeeding **A. A. Buckley**, who resigned because of ill health.

**William J. Lyons**, assistant manager of the Veterans Administration hospital at Northport, N.Y., has been appointed manager of the V.A. hospital at Rutland Heights, Mass., succeeding the late **Dr. Lester L. Weissmiller**.

**Dr. Harold A. Stokes** has been named manager of the Veterans Administration hospital at Fort Meade, S.C., succeeding **Dr. Frederick J. Bradshaw**, who was transferred to the



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V.A. hospital at Tomah, Wis. Dr. Stokes formerly was director of professional services at the South Carolina hospital.

### Department Heads

Mildred McHorney Elsey has been named assistant director of nursing at City of Hope Medical Center, Duarte, Calif. For the last five years, Mrs. Elsey has been instructor in medical-surgical nursing at Los Angeles County General Hospital School of Nursing. She also has held posts as evening supervisor, surgical supervisor, and assistant head nurse at the Medical Center of Jersey City, N.J., where she received her nursing degree. She is a nursing education graduate of New Jersey State Teachers College.

G. William Peffers has been named director of the dietary department at Michael Reese Hospital Medical Center, Chicago, succeeding Louise Wilkerson, who resigned. Mr. Peffers formerly was a supervisor with a national accounting and consulting firm specializing in hotel and institutional work. He also has been associated in various capacities with Chicago area hotels. He is a graduate of Michigan State University.



G. William Peffers

Theodora M. Jay has been named director of personnel at Beth Israel Hospital, Boston. For the last seven years Miss Jay has been industrial relations director for a firm in Waltham, Mass. She also has held various positions in education, community relations, and social service. She received a master's degree in personnel and public relations from Boston University.



Theodora M. Jay

Elva A. Hiscock has been appointed chief dietitian at West Valley Community Hospital, Encino, Calif. Previously, Miss Hiscock served as instructor in nutrition at the University of Illinois Medical School and as chief of the diet therapy section at the Veterans Administration center, Los Angeles. At the same time it was announced that Mary Rose has been named medical record librarian for the hospital. Miss Rose formerly was medical record librarian at the V. A. center in Los Angeles. She also served as chief medical record librarian at the Hospital for Special Surgery, New



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"8W"	8W-257	7 3/4" x 15 1/4"	2", 4"
"6T"	6T-657	5 1/4" x 11 1/4"	2", 4", 6", 8"
"4D"	4D-1255	5 1/4" x 7 3/4"	2", 4", 6", 8"

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York. She is president of the Southern California Association of Medical Record Librarians. **Lois Milliare** has been appointed executive housekeeper. She is a member of the National Executive Housekeepers Association and has had many years of experience in hotel and hospital housekeeping.

**Marian C. Field, R.N.**, has been appointed director of nursing at Sherman Hospital, Elgin, Ill., succeeding **Ethel Davies**, who has retired. Miss Field has been associate director of nursing at the hospital since 1954, and she will be succeeded in that post by **Jeanne L. Cotton, R.N.**, now assistant director. Mrs. Cotton's present position will be filled by **Barbara Bradbury, R.N.**

### Miscellaneous

**Roger Klein** has been appointed director of the graduate program in hospital administration at Emory University. Mr. Klein has been assistant professor of hospital administration at the University of Pittsburgh since 1956; during his tenure there he directed a study of university programs in hospital administration, under a grant from the Public Health Service. Before going to Pittsburgh, Mr. Klein was assistant superintendent at City Hospital, Cleveland. He is a graduate of the University of Chicago, where he received master's degrees in hospital administration and in marketing.



Roger Klein

**Dr. Willard C. Rappleye**, dean of Columbia University's faculty of medicine and college of physicians and surgeons since 1931, will retire on June 30. He will be succeeded by **Dr. Howard C. Taylor Jr.**, professor and chairman of the department of obstetrics and gynecology at Columbia University. Dean Rappleye has held many posts with state and national medical and educational groups, including the presidency of the Association of American Medical Colleges.

**Howard F. Cook**, administrator of Community Hospital of Evanston, Ill., has been appointed executive director of the Chicago Hospital Council, succeeding **Wendell H. Carlson**, who has been named administrator of West Suburban Hospital, Oak Park, Ill. Mr. Cook went to Evanston in October 1956; prior to



Howard F. Cook

(Continued on Page 146)

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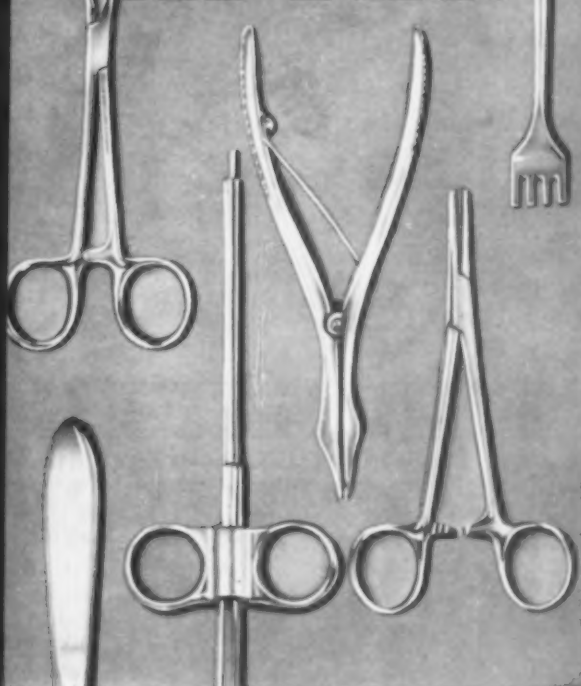
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The Halsey W. Taylor Co., Warren, O.

(Continued From Page 142)

that appointment he served six years as secretary of the council on association services of the American Hospital Association. He is a graduate of Northwestern University's hospital administration program.

**Morris London**, former administrative director at Jewish Hospital, Cincinnati, has been named research associate with the Hospital Council of Western Pennsylvania. Mr. London, a graduate of the Yale University hospital administration course, has also worked for the Ohio Department of Health in the Hill-Burton program.

### Deaths

**George P. Sheaffer**, assistant superintendent of Harrisburg Hospital, Harrisburg, Pa., died recently following surgery. He was 66. Mr. Sheaffer joined the staff of the hospital in 1945 as purchasing agent.

## THE BOOK SHELF

GUIDE FOR THE PREVENTION AND CONTROL OF INFECTIONS IN HOSPITALS. A joint project of the New York State Department of Health and the American Public Health Association. Free to residents and agencies of New York State; distributed out of state at 50 cents per copy by Health Education Service, Albany 1, N.Y. Quantity prices available on request.

Five general approaches that can be used to prevent spread of infection from one patient to another or to hospital personnel, and from hospital personnel to patient, are discussed. Clean and aseptic techniques, recognition of infections, isolation procedures, immunization, physical arrangement of various units, and use of drugs and antibiotics are presented in some detail. The booklet is illustrated with drawings of proper procedures and is indexed.

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Papers presented in this book cover the evolution of the rehabilitation concept; how to evaluate existing community resources, potential case load, financial resources, and sources of information needed in planning a center; organization, administration, professional policies, and personnel selection in the center, and federal and state sources of financial support.



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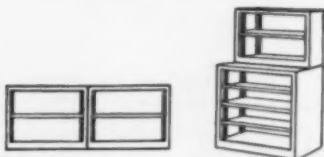
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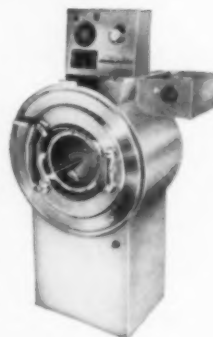
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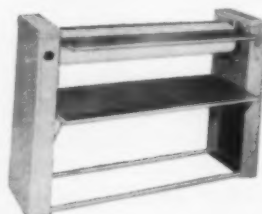
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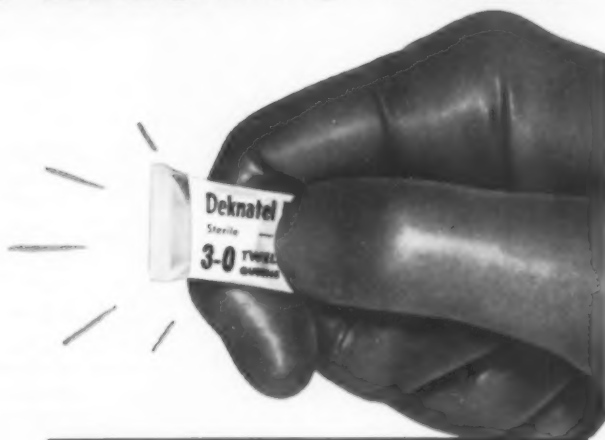
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For over seven years a code symbol has enabled restaurants and hotels to check the remarkable durability of their Libbey Heat-Treated DATED Glassware. Results of these many surveys show an amazingly high average number of servings per tumbler . . . which means extremely low tumbler cost per 1,000 servings.

The names of these leading restaurants and hotels, and full details of their own surveys, will be supplied on request.

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**ADMINISTRATOR**—X-ray technician; male 39, 7 years experience in 40-bed general hospital; excellent record and references; able to take complete charge of small general hospital, convalescent home or clinic; desires Florida location. Write or contact Robert Hansen, 1015 16th Avenue, South Milwaukee, Wisconsin.

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**ANESTHESIOLOGIST**—Diplomate, American Board; 9 years, department of anesthesiology, well known clinic, on staff medical school.

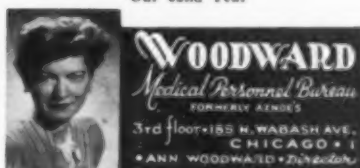
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## INTERSTATE—Continued

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**BUSINESS MANAGER**—C.P.A.; 12 years experience in public accounting; 4 years chief accountant, 200-bed hospital; prefers east.

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**EXECUTIVE HOUSEKEEPER**—6 months course, institutional management; 3 years experience.

**DIRECTOR OF NURSING**—M.A. Degree; 15 years experience; Illinois and Pennsylvania hospitals.

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**ADMINISTRATOR**—For 110-bed Southern California proprietary hospital; must be capable of being in complete charge of hospital; business background essential, salary open depending on experience and qualifications. Apply MO 219, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

**ADMINISTRATOR or OFFICE MANAGER**—Small general hospital; Milwaukee area; only experienced considered; salary open; prerequisites: accounting, credits, collections, personnel. Reply MO 225, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Ill.

**ANESTHETIST**—Nurse; RNA for 125-bed hospital; 40 hour week; salary open. Contact G. L. Crutchfield, Administrator, Ouachita County Hospital, Camden, Arkansas.

**ANESTHETIST**—Nurse; opening in obstetric department; 11:00 p.m. to 7:30 a.m.; liberal employee benefit program includes vacation, sick pay, and holidays. Write Personnel Department, St. Joseph Mercy Hospital, 900 Woodward Avenue, Pontiac, Michigan.

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**ANESTHETIST**—Nurse; female; good salary; excellent working conditions and personnel policies. Contact J. Milton Ramsour, Administrator, Memorial Hospital, Pecos, Texas.

**ANESTHETIST**—Nurse; for 200-bed hospital, staffed with 5 nurse anesthetists. Contact T. W. Patterson, Administrator, Herbert J. Thomas Memorial Hospital, South Charleston 3, West Virginia.

**COMPTROLLER**—Peoples Community Hospital Authority, a state agency operating three general acute care hospitals in the metropolitan Detroit area has a new opening for an individual who is thoroughly familiar with accounting matters; preferably well versed in hospital accounting, fund accounting and the preparation and supervision of budgets; salary \$8,600 to \$12,000; start about May 1, 1958. Reply in writing giving full particulars to K. W. Gremore, Executive Director, Peoples Community Hospital Authority, 3030 Wayne Road, Wayne, Michigan.

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**DENTAL HYGIENIST**—Must have completed a course in dental hygiene at a recognized school, college, or university; salary range \$3360-\$3960, liberal employee benefits. Apply Personnel Director Ancora State Hospital, Hammonton, New Jersey.

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**DIETITIAN—ADA**: 125-bed hospital; 40 hour week; salary open; to replace retiring dietitian. Contact G. L. Crutchfield, Administrator, Ouachita County Hospital, Camden, Arkansas.

**DIETITIAN—A.D.A. or equal**: full charge of department in 45-bed hospital; 75 miles east of St. Louis, Missouri; salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

**DIETITIAN**—Opening in 400-bed hospital which is adding 120-bed rehabilitation unit; excellent opportunity in therapeutic or administrative work for A.D.A. registered person; salary commensurate with training and experience; liberal benefits. Apply Personnel Director, Iowa Methodist Hospital and Raymond Blank Memorial Hospital for Children, Des Moines, Iowa.

**DIETITIAN—Therapeutic**: Borgess Hospital, 340-bed general hospital; duties include cafeteria, therapeutic diet planning, patient contact, general supervising and teaching student nurses; a large full-time medical staff and house staff; salary open, progressive personnel policies. Apply Hospital Administrator, Borgess Hospital, Kalamazoo, Michigan.

**DIETITIANS—Therapeutic**: large teaching hospital, 6 units affiliated with Washington University School of Medicine; monthly staff salaries begin at \$300 based on a 40 hour week; due to the need for more professional dietetic hours in the medical center, dietitians are allowed overtime work and are paid at an hourly rate based on monthly salaries; two weeks vacation; social security; Blue Cross. Apply, Director of Dietetics, Barnes Hospital, 600 South Kingshighway, St. Louis 10, Missouri.

**DIETITIAN—A.D.A. or equal**: full charge of department; 55-bed general hospital; JCAH approved; modern kitchen; salary open. Apply Administrator, Lakeview Memorial Hospital, Bath, New York.

**DIETITIAN—College graduate**, salary range \$3840-\$4740, forty-hour week, liberal employee benefits. Apply Personnel Director, Ancora State Hospital, Hammonton, New Jersey.

**DIETITIAN—Prefer A.D.A. member**; both administrative and therapeutic work; modern all electric air-conditioned kitchen. For information write Harriette S. Oeffiger, Personnel Director, Wilson Memorial Hospital, Johnson City, New York.

**DIETITIAN**—Position to be open as head of department in May; this is a challenging opportunity to assume full responsibility in a new 92-bed general hospital; must have had administrative experience at least as an assistant; starting salary \$4,500; 40 hour week; liberal vacation policy, sick leave allowed, social security. Apply Hospital Director, Forest City Hospital, 701 Parkwood Drive, Cleveland 8, Ohio.

**STAFF DIETITIANS**—One teaching; one therapeutic; A.D.A. members, hospital recently expanded to 450-beds, located in residential district; approved by J.C.H.A.; dietary facilities entirely new and air conditioned; dietetic program integrated with N.L.N. approved school of nursing, affiliated with Medical Research Institute 40 hour week, broad personnel policies and benefits; salary open. Apply Miss Rosemary E. Brown, Director of Dietetics, The Toledo Hospital, Toledo 6, Ohio, or call Greenwood 2-1121.

**DIETITIANS**—(a) Supervisor for new cafeteria (b) assistant therapeutic; 40 hour week; two, three or four weeks vacation depending upon length of service; liberal sick leave; wide range of salaries; two 350-bed private general hospitals. Apply Director of Dietetics, Youngstown Hospital Association, Youngstown, Ohio.

**DIETITIAN**—Fully qualified, female; member of the A.D.A., registered; salary open; to take charge of the department, prepare and supervise general and therapeutic diets; 95-bed capacity. Apply Administrator, Bethania Hospital, Wichita Falls, Texas.

**DIETITIANS—ADA registered**: positions in a system of 10 new general hospitals with large out-patient department; educational material and visual aids being developed for the instruction of patients and families; modern dietary department, centralized trayveyor; employee and visitor cafeteria; we are still developing nutrition and dietary instructions; hospitals in West Virginia and Kentucky; salary ranges begin at \$4860 and \$5340 per annum, depending on your qualifications; annual increments; 40 hour week, 7 paid holidays, 4 weeks paid vacation; employee health program; social security plus retirement plan. Write Miners Memorial Hospital Association, Box #61, Williamson, West Virginia.

**DIRECTOR OF NURSES—B.S. degree** in Nursing Education and experience or Masters Degree; salary open, 40-hour week, good personnel policies; hospital fully approved by J.C.H.A. Apply MO 215, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

**DIRECTOR OF NURSING SERVICE**—Expanding 300-bed West Coast hospital, metropolitan location; salary open; desire candidate with 2 years demonstrated progressive administrative experience plus MA in Nursing Administration, or 6 years comparable experience. Write MO 218, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11.

**DIRECTOR, SCHOOL OF NURSING** — For accredited diploma school of nursing with student body of 170; Masters degree required; Baptist preferred; must be Protestant; 40 hour working week; salary commensurate with qualifications; excellent personnel policies, social security, group hospitalization. Apply MO 224, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

**DIRECTOR OF NURSES—100-bed J.C.A.H.** approved, general hospital with 3 year diploma school of nursing; east; expansion program in process; good working conditions, social security and group hospitalization; position open July 1, 1958; Degree required; salary open. Apply MO 221, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

**DIRECTOR OF NURSING**—Excellent opportunity for person with head nurse, supervisor or administrative supervisor experience; B.S. degree desired; to organize and develop present service, plan for new hospital; complete responsibility, pleasant job environment. Opportunity to work toward master's degree; salary \$6000 to \$6600. Apply Bethesda Hospital, North Hornell, New York.

**DIRECTOR OF NURSES** for 52-bed community hospital; salary range \$475-550 per month; sick leave, vacation and holiday benefits. For full details contact Henry A. Kallio, Administrator, Lompoc Community Hospital, Lompoc, California.

**DIRECTOR OF NURSING**—If you are looking for a challenging opportunity we would like to hear from you; we are a 92-bed general community hospital serving a densely populated area, located in northeast Cleveland, 40-hour week, social security, liberal vacation. Write, giving full particulars on experience to J. C. Gliemmo, Director, Forest City Hospital, 701 Parkwood Drive, Cleveland 8, Ohio.

**DIRECTOR OF NURSING SERVICE**—300-bed Catholic general hospital; NLN accredited school of nursing; must have BS degree in nursing service, but a Master's preferable; though open the salary meets the OSNA minimum standards. Apply Personnel Director, Providence Hospital, 700 N. E. 47 Avenue, Portland 13, Oregon.

**DIRECTOR—NURSING SERVICE AND EDUCATION**—300-bed Protestant general hospital, expansion program in progress, with 150-student School of Nursing, needs director of nursing to be responsible for nursing service and school of nursing; applicants should be in excellent health, between approximate ages of 35-45; liberal salary range and benefits; excellent working conditions in one of the midwest's foremost institutions, centrally located in the city and convenient to outstanding residential and shopping facilities. Contact Mr. S. W. Martin, Administrator, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

**ASSISTANT DIRECTOR OF NURSING**—Service and education; large midwestern hospital in pleasant suburban area; furnished apartment available; near excellent shopping facilities and transportation; paid vacation, sick leave and retirement plan. Send resume of experience and training to MO 220, The Modern Hospital, 919 N. Michigan Ave., Chicago 11, Illinois.

**ASSISTANT TO DIRECTOR OF NURSING**—To assist in directing nursing care in O.B. unit of 629-bed general hospital; beginning salary \$5,967 with increases to \$7,111; liberal vacation, longevity and retirement benefits; prefer B.S. in nursing. Apply Flint Civil Service Commission, City Hall, Flint 2, Michigan.

**EDUCATIONAL DIRECTOR**—For accredited diploma school of nursing; 270-bed modern, accredited, general hospital and teaching institution for interns, residents, X-ray and laboratory technicians; school affiliation with Oberlin College and Metropolitan County Hospital for specialties; rapidly expanding community near universities; excellent personnel policies; salary commensurate to degree and experience. Write Director of Nursing, Elyria Memorial Hospital, Elyria, Ohio.

**EXECUTIVE DIRECTOR**—Applicant should be graduate of Hospital Administration Course. Apply to Dr. J. E. de Belle, Executive Director, The Montreal Children's Hospital, 2300 Tupper Street, Montreal, Quebec.

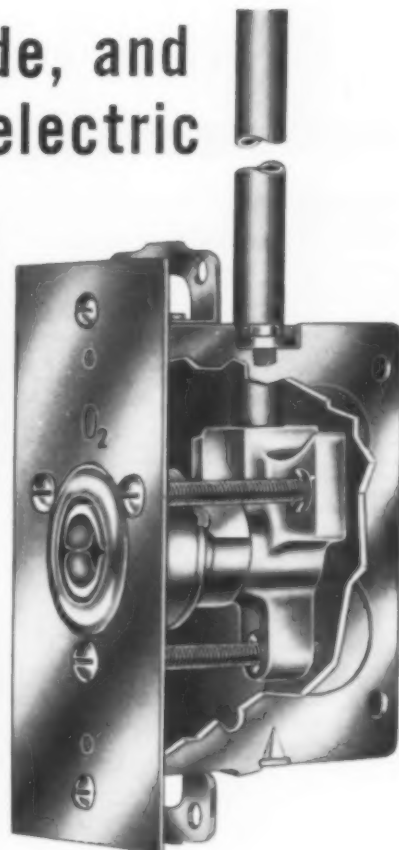
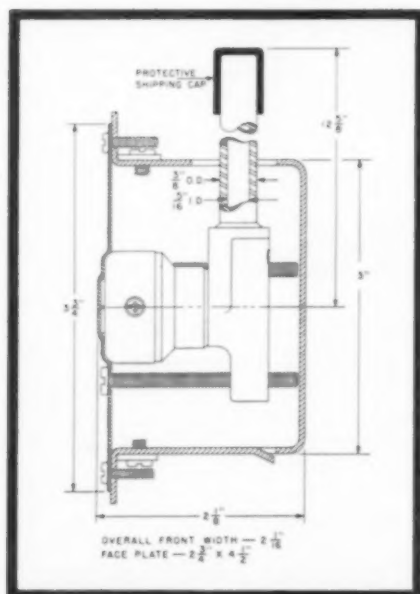
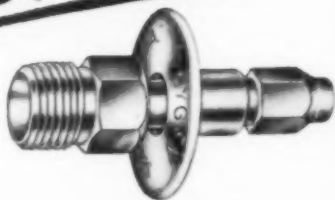
**INSTRUCTOR**—Nursing arts; qualified to take full responsibility for the course and guiding assistant instructors; teaching experience and masters degree preferred; monthly salary \$500.00, if qualified; diploma school, fully accredited. Reply MO 226, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

**CLINICAL INSTRUCTORS**—For medical and surgical nursing on evening shift; liberal personnel policies; Evangelical Deaconess Hospital School of Nursing, 6150 Oakland Ave., St. Louis 10, Mo.

(Continued on page 156)

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# classified advertising

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**INSTRUCTORS**—Clinical: medical and surgical nursing, nursing of children and obstetric nursing for diploma program with 50 students; very good personnel policies and congenial working conditions; academic preparation and/or experience desirable; salary commensurate with preparation and experience. Write Director, School of Nursing, St. Joseph's Hospital, St. Joseph, Missouri.

**INSTRUCTOR OF NURSES**—B.S. Nursing Education, salary range \$4560-\$5460; new nurses' home, liberal employee benefits. Apply Personnel Director, Ancora State Hospital, Hammonton, New Jersey.

**INSTRUCTOR**—Medical-clinical: must have B.S. degree in Nursing Education and a minimum of two years experience in two of the following positions: instructor, assistant instructor, head nurse; 366-bed hospital; 150 student school of nursing with three year diploma course. Contact Personnel Department, Milwaukee Hospital, 2200 West Kilbourn Avenue, Milwaukee 3, Wisconsin.

**INSTRUCTOR**—Clinical: medical-surgical formal and clinical teaching in NLN temporary accredited diploma program; integrated course correlated with other courses over a 39-week

period during the first year; no service responsibilities, permissive atmosphere for joint planning and function; B.S. degree required; liberal personnel policies, salary commensurate with experience and preparation. Apply to Director, School of Nursing, Memorial Hospital, Pawtucket, Rhode Island.

**LIBRARIAN**—Registered or equal; full charge of department in 45-bed hospital; 75 miles east of St. Louis, Missouri; salary open. Apply Administrator, Salem Memorial Hospital, Salem, Illinois.

**LIBRARIAN**—Medical record; registered to assume charge of record room; 135-bed general hospital; 40 hours; salary open. Contact Miss G. A. Cooper, Woman's Hospital, Cleveland 6, Ohio.

**LIBRARIAN**—Medical record; assume charge records department; 58-bed cancer hospital; cancer registry; standard nomenclature, statistical reports; salary open. Write Miss F. C. Martin, Oncologic Hospital, 53rd & Powelton Avenue, Philadelphia 4, Pa.

**LIBRARIAN**—Medical records; Utah Health Department, Salt Lake City; salary on one of these steps: \$330-345-360-380-400-425. For information write to Merit Council, 174 Social Avenue, Salt Lake City 11, Utah.

**MISCELLANEOUS—NURSE**: 18-bed hospital near summer and winter resort area; medical and treatment nurse 7-3; beginning salary

\$335; also need Laboratory Technician eligible for California registration, beginning salary \$375; good personnel policies. Write Southern Inyo Hospital, Lone Pine, California.

**MISCELLANEOUS**—Openings for Anesthetist and two Registered Nurses for supervision; 38-bed general hospital; salary open, good personnel policies. Contact Superintendent Red Wing City Hospital, Red Wing, Minn.

**NURSING MISCELLANEOUS**—Portland, Oregon, is a fine place to live; The University of Oregon Medical School Hospital is a fine place to work; Staff positions open in Medical, Surgical, Pediatric, O.R. and Isolation units; beginning salary \$310.00 per month with six months' experience; liberal personnel policies; opportunities for taking courses leading to baccalaureate or masters degrees at nursing school on campus; reduced tuition rates for employees. Write for information to Director of Nursing, University of Oregon Medical School Hospital, Portland 1, Oregon.

**NURSES—Professional**: For Arizona; new 75-bed non-profit, community hospital, (fully refrigerated) opening in May; supervisors, head nurses needed for all shifts; starting salary \$325.00 to \$360.00 per month, 40 hour week, liberal sick leave, vacations, uniforms laundered. Address all inquiries c/o Administrator, Yuma District Hospital, P.O. Box 222, Yuma, Arizona.

(Continued on page 158)

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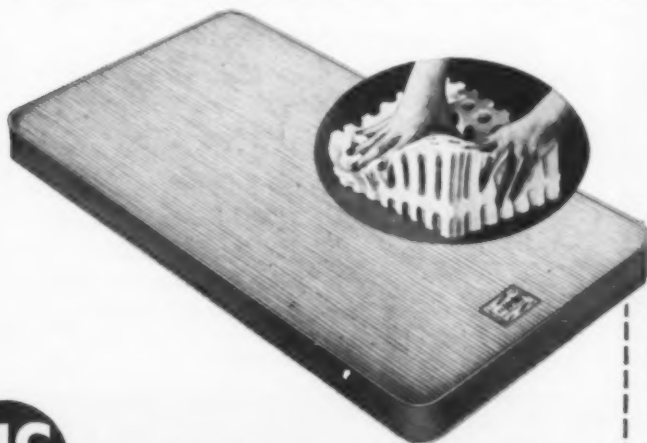
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## POSITIONS OPEN

**NURSES**—Graduate; for private hospital in California's Central Valley; starting salary \$320 per month days; \$335 per month nights; 40 hour week, paid vacations, etc.; reasonable housing available. For information write Administrator, West Side Community Hospital, Post Office Box B, Gustine, California.

**NURSES**—Operating room and staff; for 227-bed pediatric hospital in sunny California; salary \$315 per month with differential for operating room and evening and night duty; 5 day, 40 hour week; liberal personnel policies including vacation, sick time and retirement. Apply Director of Nursing, Childrens Hospital Society, 4614 Sunset Blvd., Los Angeles 27, California.

**NURSES**—Registered; for modern psychiatric hospital in Greens Farms, Connecticut; 1 hour from New York; Hall-Brooke nurses have 8-hour duty, optional 5 or 6 days week, nicely furnished private rooms; excellent salary, 7 paid holidays annually, or equivalent; sick leave; vacation, minimum 2 weeks, maximum 4 weeks dependent on length of service; profit-sharing plan; psychiatric experience not necessary; registered or eligible in State of Connecticut. Apply Mary R. Walsh, R.N., Director of Nursing, Hall-Brooke, Box 31, Greens Farms, Connecticut. Tel. Westport—Capital 7-5195.

**NURSES**—Staff; staff positions in all clinical areas including psychiatry, poliomyelitis and respiratory center in new, 800-bed air conditioned hospital; 40-hour week; 3 weeks vacation annually; beginning salary; staff nurses, \$275 monthly; periodic increments; opportunity for college study through bachelor's degree program. Write Director of Nursing Service, Eugene Talmadge Memorial Hospital, Medical College of Georgia, Augusta, Georgia.

**NURSE** — Registered; interested geriatrics nursing for infirmary of medium sized, outstanding home for elderly women near Chicago; five day week, full maintenance. Write Director, Box 111, Hinsdale, Illinois or call FA 3-2250.

**NURSES**—Registered; openings due to retirement; 600-bed Tuberculosis Hospital located forty miles south of Jackson; beginning salary \$200 month with full maintenance; merit increases; personnel policies also include retirement pension plan, social security, 15 days vacation, 15 days sick leave, and 6 annual holidays. Write Director of Nursing, Mississippi State Sanatorium, Sanatorium, Mississippi.

**NURSE**—Registered; operating room; good salary; excellent working conditions and personnel policies. Contact J. Milton Ramsour, Administrator, Memorial Hospital, Pecos, Texas.

**NURSE**—Operating room; for modern air-conditioned, two room suite, in 52-bed general hospital; 12 days sick leave, 2 weeks vacation annually, paid holidays, annual bonus, 40-hour week; salary open. Apply Director of Nurses, Parkview Hospital, 1920 Parkwood Avenue, Toledo 2, Ohio.

**NURSE**—Registered; floor supervisor; 35-bed general hospital; starting salary \$320 per month; differential for night duty; excellent working conditions and personnel policies. Contact J. Milton Ramsour, Administrator, Memorial Hospital, Pecos, Texas.

**NURSES**—Psychiatric; for supervising psychiatric buildings and attendants; mature experienced; \$3,000 per year, board, room and laundry available at \$480 per year; social security and pension. Send full information to Director of Nurses, Brattleboro Retreat, Brattleboro, Vermont.

**PHYSICAL THERAPIST**—Male or female; for new department in 225-bed general hospital; salary open, personnel policies excellent; Contact Administrator, Allen Memorial Hospital Waterloo, Iowa.

**PHYSICAL THERAPIST**—Male or female, for small new hospital, Bellows Falls, Vermont; new physical therapy department; please give qualifications, experience and salary expected in first letter. Apply to R. C. Mittica, Administrator, Rockingham Memorial Hospital, Bellows Falls, Vermont.

(Continued on page 160)

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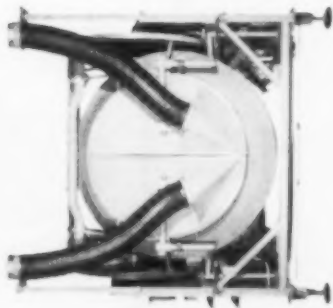
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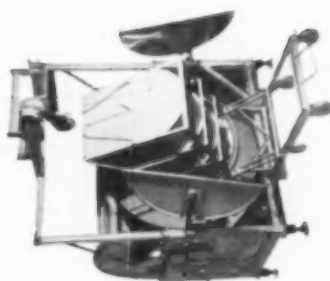
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## POSITIONS OPEN

**SUPERVISOR-INSTRUCTOR** — Operating room; 200-bed general hospital; NLN fully accredited school of nursing; 96 students; 40 hour week; special clinical preparation in operating room supervision; salary open, liberal personnel policies. Apply Director of Nursing, Middlesex Memorial Hospital, Middletown, Connecticut.

**SUPERVISOR**—Psychiatric; 45-bed unit, charity, private; air conditioned; no long term patients; progressive program; meals; uniform laundry; benefits; \$320.00 per month; \$15.00 raise after 6 months. Apply Director of Nursing, Duval Medical Center, Jacksonville, Florida.

**SUPERVISOR**—Clinical instructor; for 22-bed, open ward, new psychiatric unit; NLN accredited; degree or post course, teaching experience desired; salary open. Apply Nurse Administrator, Northwest Texas Hospital, Amarillo, Texas.

**SUPERVISOR**—Pediatric teaching; 37-bed pediatric ward, 250-bed hospital, full NLN accreditation, JACH; degree and experience preferred; liberal personnel policies; salary open. Apply Nurse Administrator, Northwest Texas Hospital, Amarillo, Texas.

**TECHNOLOGIST**—Laboratory; 250-bed hospital; salary open. Apply MO 171, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

**TECHNICIAN** — Laboratory-X-Ray; certified; \$300 guarantee plus commissions, possible earnings \$400-\$500; small hospital soon to expand; Mountain village, elevation 7,000, summer area, cabins, fishing, trailing, horse racing, winter skiing; New Mexico; nurses home, new attractive for female; no quarters furnished for male; ideal climate for asthma, healthful-restful. Apply MO 223, The Modern Hospital, 919 N. Michigan Avenue, Chicago 11, Illinois.

**TECHNICIAN**—Laboratory; 236-bed general hospital 30 miles from New York City; interesting position with advancement in progressive hospital. Contact Personnel Office, Morristown Memorial Hospital, Morristown, New Jersey.

**TECHNICIAN**—X-ray trained; required to manage one man radiology department, doing routine radiography and electrocardiography in U.S. town of 5000; salary commensurate with experience. Contact Leon Bennett-Alder, North Country Hospitals, Gouverneur, New York; Telephone 960.

**TECHNICIAN**—Laboratory; with knowledge of X-ray; new 40-bed hospital. Contact Mrs. Arrabella Olson, RN, Warren Hospital, Warren, Minnesota.

**TECHNICIAN** — Chief laboratory; Brightlook Hospital, 10 Summer Street, St. Johnsbury, Vermont; 52-bed accredited general hospital; laboratory under supervision of pathologist; salary \$400 per month if well qualified. Write or telephone Ralph H. Ross, Acting Administrator, Pioneer 8-2311.

**TECHNOLOGISTS**—Medical registered 160-bed general hospital, college town, 20 miles west of Milwaukee, major expansion program including new department of laboratory medicine started in spring of 1957; affiliation with Carroll College for training of medical technologists now in development stage; full time pathologist. Apply Personnel Department, Waukesha Memorial Hospital, 725 American Avenue, Waukesha, Wisconsin.

**TECHNICIAN** — Laboratory and X-ray; for small hospital in Wyoming, 5 day week subject to call every other week; must be willing to help in record room and office; salary depending on qualifications and ability. Apply Administrator, St. John's Hospital, Jackson, Wyoming.

(Continued on page 162)

## Family-Centered Maternity Nursing

BY ERNESTINE WEIDENBACH

Associate Professor of Obstetrical Nursing,  
Yale University School of Nursing

Foreword by HAZEL CORBIN

Director, Maternity Center Association, New York

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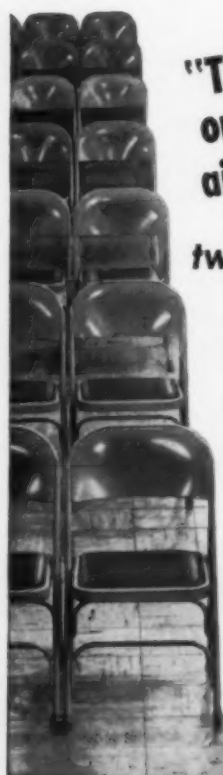
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(Continued on page 164)

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**EXECUTIVE PERSONNEL**—(a) Business manager; voluntary general hospital, 400-beds; preferably one able to take complete charge, not interested in becoming administrator; east. (b) Controller; 900-bed general hospital; experience in hospital field desirable; university city, midwest; \$9000. (c) Controller to serve 3 hospitals, all in one city; combined capacity, 400; \$8500-\$12,000. (d) Credit manager; 250-bed hospital, Florida. (e) Food service director; 275-bed hospital; university city, west. (f) Food service director; student activities building; leading university, south. (g) Personnel and purchasing directors; 400-bed general hospital; newly created posts; university city, midwest. (h) Chief pharmacist; 400-bed hospital; vicinity New York City; \$6000. MH4-5

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**FACULTY POSTS**—(a) Instructor; complete charge clinical division; state college of nursing; \$6500 minimum; south. (b) Educational

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(Continued on page 166)

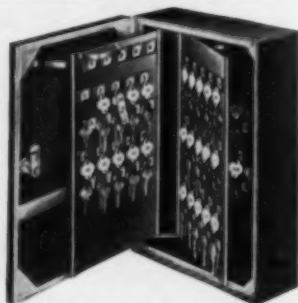
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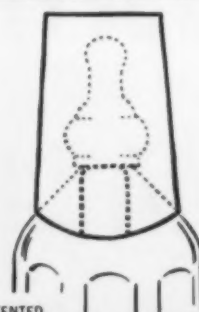


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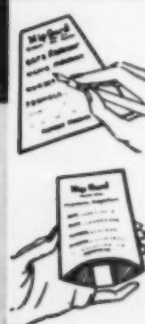
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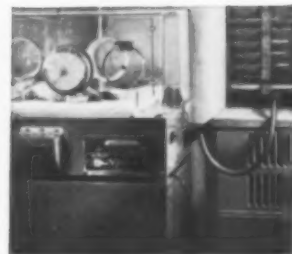
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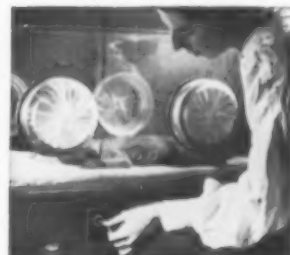
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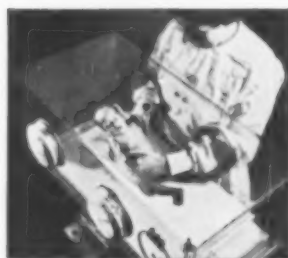
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ASSISTANT ADMINISTRATORS—(a) 150-bed hospital; Ohio; MS degree plus business background; salary \$8,500. (b) 250-bed hospital; Illinois; degree plus business background; salary \$7,500. (c) 150-bed hospital; Illinois;

### MEDICAL EMPLOYMENT—Continued

must have accounting background; salary \$7,200. (d) Large State Hospital; west; salary \$6,500. (e) 200-bed hospital; south; salary \$6,000; MS degree required. (f) 300-bed hospital; Pennsylvania; salary open. (g) 300-bed hospital; Ohio; salary open.

PERSONNEL DIRECTOR—(a) Male, with BS or MS degree; 350-bed hospital; Ohio; salary open. (b) Large State Hospital; salary \$500 per month. (c) 400-bed hospital; salary open.

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X-RAY TECHNICIANS—(a) Chief; \$375 to \$400 per month; Illinois.

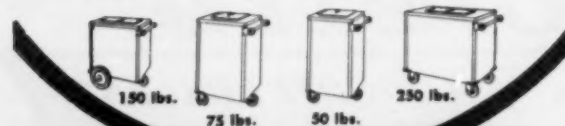
MEDICAL RECORDS LIBRARIAN — (a) Ohio; 300-bed hospital; salary \$500 per month. DOCTOR ANESTHETISTS—(a) Illinois; 3 hospitals in area; fee basis.

(Continued on page 168)



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**PHARMACISTS**—(a) Staff; southwest; 400-bed hospital; \$5700. (b) Staff; California; 375-bed hospital; 6 in department; \$7200. (c) Staff; east; man or woman; 350-bed hospital in resort area; \$5700. (d) Staff; south; large hospital affiliated with university medical school, eight in department; \$5000 minimum. (e) Chief; south; 300-bed hospital in city of 50,000; 3 qualified assistants; \$6500. (f) Chief; Pacific Northwest; 100-bed hospital; handle all purchasing; \$5700.

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## SHAY—Continued

as administrator; \$600-\$700. (c) South; 250-bed hospital; 5 nurse anesthetists; \$7800. (d) Pacific Northwest; 50-bed hospital in large city; all major surgery; 4 nurse anesthetists; \$6000. (e) Southwest; 115-bed hospital; 4 nurse anesthetists; college town of 35,000; \$6000. (f) East; 300-bed teaching hospital; \$6000.

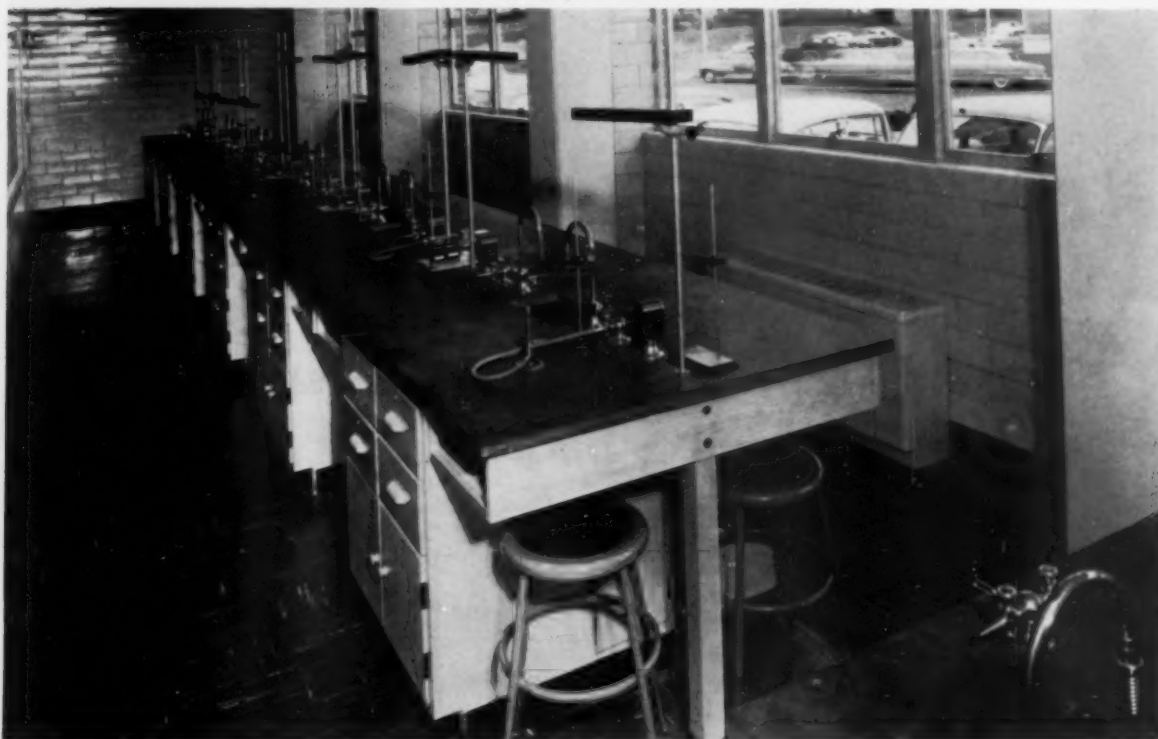
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(Continued on page 170)



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We do have many interesting openings for Administrators, Physicians, Anesthetists, Directors of Nurses, Dietitians, Medical Technicians, Therapists, and other supervisory personnel.

No registration fee

Agency

(Continued on page 172)

### INDIANA MEDICAL BUREAU

212 Bankers Trust Bldg.

Indianapolis, Indiana

Opportunities in most areas for Administrators, Medical Directors, Anesthesiologists, Pathologists, Radiologists, Resident Physicians, Laboratory and X-Ray Technicians, Therapists, Medical Records Librarians, and all areas of supervisory hospital and medical personnel.

Information about

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is available from the

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New and used hospital equipment bought and sold. Large stock on hand for the physician, hospital and laboratory. Write for what you want or have for sale.

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In Reykjavik, Iceland; Durban, South Africa; Indonesia, Israel, Arabia, Italy, China, Switzerland, Norway, Latin America and many other places far from our home—all over the world—people like and buy Armstrong Baby Incubators. Naturally—in every one of the 48 states, as well as Canada, Alaska, Hawaii and 80 other countries—hospitals and physicians like and buy Armstrong Baby Incubators. Incidentally, if you'd like the Armstrong X-4 Incubator operating instructions in some foreign language write and ask for a free copy—perhaps we have it.

### THE GORDON ARMSTRONG CO., INC.

502 Bulkley Building

Cleveland 15, Ohio

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for HOSPITALS • INSTITUTIONS



### NO. 1053 SINGLE TRAY STAND

Sturdy, handsome folding stand, of 1" heavily chromed steel tubing. Non-marring plastic gliders. Easy-to-clean black and white Saran webbing. Completely sanitary. 31½" high.

Other Sturd-i-brite items:

- Triple Tray Stands
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- Costumers

See your local dealer.

### THE GAYCHROME CO. Sturd-i-brite Div. H

1079 Southbridge St.  
Worcester 10, Mass.

When surgery, fever and other debilitating conditions increase the patient's requirements for B complex plus C, Berocca-C provides a balanced comprehensive formula in a stable injectable form **READY FOR IMMEDIATE USE.**

Berocca-C is time saving, for **IT MAY BE ADDED TO INFUSION FLUIDS**, or given by intramuscular or slow intravenous injection; it comes in labor-saving "color-break" ampuls; and **IT IS ECONOMICAL.**

*Supplied:* Berocca-C, 2-cc ampuls, 20-cc vials.

Berocca-C 500, duplex ampul packages, boxes of 50.

Each 2-cc ampul of Berocca-C contains thiamine HCl 10 mg, riboflavin 10 mg, niacinamide 80 mg, pyridoxine HCl 20 mg, d-panthenol 20 mg, d-biotin 0.2 mg and ascorbic acid 100 mg. When higher amounts of vitamin C are desired, use the Berocca-C 500 duplex package containing a 2-cc ampul of Berocca-C plus an additional 2-cc ampul of vitamin C injectable 400 mg.

**ROCHE LABORATORIES**

**DIVISION OF HOFFMANN-LA ROCHE INC • NUTLEY 10 • N. J.**

**BEROCCA® -C AND  
BEROCCA® -C 500**

**ROCHE**

The advertisement features a black and white photograph of a doctor in a white coat, seen from the side, examining a patient lying in a hospital bed. The patient's head is resting on a pillow. The scene is dimly lit, with a light source visible in the background. The text "BEROCCA® -C AND BEROCCA® -C 500" is printed in large, bold, sans-serif capital letters on the left side of the image. Below this text is the Roche logo, which consists of the word "ROCHE" in a stylized font inside a horizontal oval.

# classified advertising

## FOR SALE

### NURSING AND MEDICAL BOOKS

We have in stock every nursing or medical book published. Lowest prices with unexcelled service. Write Chicago Medical Book Company, Jackson and Honore Streets, Chicago 12, Illinois.

## SCHOOLS—SPECIAL INSTRUCTION

GRADUATE HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA offers a four month course in operating room technic and management to registered graduates of accredited schools of nursing. Registration fee \$20.00. Full maintenance and \$30.00 monthly cash allowance given. Apply to Director of Nursing Service, 1818 Lombard Street, Philadelphia 46, Pennsylvania.

## SCHOOLS—SPECIAL INSTRUCTION

The CHICAGO LYING-IN HOSPITAL AND DISPENSARY of the University of Chicago offers a six-months course in OBSTETRIC NURSING to qualified graduate nurses. The course includes all phases of maternity nursing. The student may elect experience in one special area for two months of the course. Modern, attractively appointed kitchenette apartments are provided. Adequate allowance is made for food and laundry. For further information, write to the Director of Nursing, 5841 Maryland Avenue, Chicago 37, Illinois.

The PROVIDENCE LYING-IN HOSPITAL offers to qualified graduate nurses a four months supplementary clinical course in Obstetrics. Full maintenance and stipend of \$75.00 a month is provided. For full information, apply to the Director of Nurses, Providence Lying-In Hospital, Providence 8, Rhode Island.

## SCHOOLS—SPECIAL INSTRUCTION

UNIVERSITY OF MICHIGAN School for Nurse Anesthetists offers a 16 month course for nurses interested in anesthesia. Accredited by the American Association of Nurse Anesthetists. The training includes all technique in Inhalation, Intravenous, and rectal anesthesia. Unlimited opportunities for endotracheal intubation and open chest anesthesia. Stipend provided. For information write, School for Nurse Anesthetists, University Hospitals, Ann Arbor, Michigan.

SCHOOL FOR LABORATORY TECHNICIANS—Duration of course, 1 year. Tuition, \$100.00; approved by the American Medical Association. For further information, write the Director of Laboratories, Barnes Hospital, 600 S. Kingshighway, St. Louis, Missouri.



**IT HAS LONG BEEN RECOGNIZED** that institutions are confronted with problems inherent to all types of business organizations.

Through its 43 fully staffed offices Pinkerton's is rendering service to hundreds of hospitals throughout the United States and Canada. Should you have security or confidential problems, we shall be glad to consult with you relative to the application of our service to your needs.

*You will find Pinkerton's new brochure on hospital service both interesting and informative. Send for your free copy now without obligation.*

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## SHELBY brings you EXPERT HELP on all your printed forms and systems

Shelby Salesbook has been serving hospitals for over 50 years. Your own Shelby representative knows hospital problems. He's more than a printing salesman... he can help you cut record-keeping time, simplify and reduce the number of forms you use, and he can show you how to eliminate errors and lost charges. Finally, he can provide you with every type of form you use... at a minimum cost. Consult him... there's no obligation. It will save you time and money.



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### *Best Way: On a Burroughs Sensimatic Accounting Machine*

**Naturally! When you do patient accounting on a Sensimatic, you cut clerical costs, clerical work to a new minimum.**

- **HANDLE SERVICE CHARGE SLIPS ONCE.** Sensi-matic's 19 memory units accumulate charges of each department during daily posting of patients' statements. Day-end totals? A simple matter of letting the machine automatically distribute these stored-up totals to the proper accounts.
- **QUICKLY PROCESSED, ITEMIZED PATIENTS' BILLS** show charges to patient and to insurance com-

pany. The neat, understandable carbon duplicate usually satisfies insurance company requirements.

- **SIMPLICITY, FLEXIBILITY OF OPERATION.** Newly trained operators quickly master the Sensimatic, can soon use it to perform other accounting jobs—inventory, accounts payable, budget and payroll.

Each of these advantages is a money-saving step toward the time when the Sensimatic will have paid for itself—and it doesn't take long! Call our nearby branch today for full details and a free demonstration. Burroughs Division, Burroughs Corporation, Detroit 32, Michigan.



# BURROUGHS

## Sensimatic Accounting Machines

Burroughs and Sensimatic—TM's



Send for this free booklet:  
*"Burroughs Accounting Plans for Hospitals"*



## *New yellow tinted* **AEROPLAST® PROVIDES ADDED BENEFITS IN PATIENT CARE**

In clinical use as a primary surgical dressing, as a secondary dressing after removal of initial gauze-tape, or as a skin protectant to prevent or clear excoriation—AeroPlast surgical dressing demonstrates\* unique advantages:

### **CHOICE OF SIZES**

- 12 oz. tinted**  
for frequent  
operating room use
- 3 oz. tinted**  
convenient for surgical  
carts and for office use
- 6 oz. clear**  
the original AeroPlast  
still available
- Rx no longer needed**

- **easy, rapid spray-on technic**
- **conforms to problem wound contours without tape or bulk**
- **plastic film forms waterproof bacterial barrier; antibacterial; dependably sterile dressings**
- **protects incision and adjacent area from drainage, urine, feces and other outside contamination**
- **permits visual inspection without removing dressing; allows free access for palpation and auscultation; no undesired restriction of respiration or circulation**
- **increases patient comfort; no bulk, no tape; non-sensitizing, non-allergenic**

**16 MM COLOR-SOUND FILM** now available  
for professional meetings . . . to schedule write:



**CORPORATION**  
420 Dellrose Avenue,  
Dayton 3, Ohio

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*\*Reports of clinical use sent on request*

# WHAT'S NEW FOR HOSPITALS

APRIL 1958

Edited by BESSIE COVERT

TO HELP YOU get more information quickly on the new products described in this section, we have provided the convenient Readers Service Form opposite page 196. Check the numbers on the card which correspond with the numbers at the close of each descriptive item in which you are interested. The MODERN HOSPITAL will send your requests to the manufacturers. If you wish other product information, just write us and we shall make every effort to supply it.

## Upholstered Lounge Furniture Is Attractive and Rugged

A line of upholstered furniture for waiting rooms, lounges, nurses' homes and other areas is introduced by Simmons Company. An entirely different, new type of



construction assures maximum comfort in the chairs and sofas. Pieces suitable for every hospital seating need are included in the new line: chairs, two-seat settees and sofas and three and four-seat sizes.

Featuring the new "Comfortorc" construction, Simmons Upholstered Furniture provides complete seating comfort for persons of every weight. The "Comfortorc" principle automatically adjusts the pitch of the seat to the proper seating angle for the individual. Each seat is so constructed that persons of different weights can sit comfortably on the same sofa without sliding together. The chairs have a base cushioning of Beautyrest coils with a loose cushion of foam rubber for maximum comfort. Designs and styles have been carefully coordinated to fit into all hospital decorating plans. Upholstery materials can be selected from the complete Simmons line of fabrics, Naugahyde, and genuine leather in the Simmons exclusive "Continental" texture. Simmons Company, Merchandise Mart, Chicago 54.

For more details circle #184 on mailing card.

## Hinged-Door Sterilizer for Laboratory Use

A new Barnstead Autoclave with hinged doors for full opening to accommodate large trays and other large items is now available. Units can be supplied in either single or double wall construction and a new built-in safety device locks the door handle to prevent rotation while there is pressure in the chamber. The new sterilizers have automatic pressure control, dial-type thermometers, chamber pressure gauge, automatic air evacuation and stainless steel jackets. They can be supplied with a special Type A automatic control unit for the complete sterilizing cycle. The

sterilizers are available in gas, electric or steam heated models and are constructed of Monel and stainless steel in all-welded, rivetless design. Barnstead Still & Sterilizer Co., 194 Lanesville Terrace, Boston 31, Mass.

For more details circle #185 on mailing card.

## Automatic Ultrasonic Washer for Instruments and Glassware

The Tomac Model B Ultrasonic Washer is an all-automatic machine for the thorough cleaning of surgical instruments and laboratory glassware. Similar in size and control features to automatic home washers, the stainless steel unit is designed to fit in with central supply or surgical suites and will wash and rinse up to 100 instruments in a matter of minutes. The operator loads the machine and flicks a dial to start operation, then goes about her work while the washer cleans inner and outer surfaces, hinges and other areas difficult or impossible to reach in hand cleaning. The



push button wash-and-rinse feature of the unit reduces handling and thus reduces possibility of damage to instruments and glassware. The washer is manufactured to American specifications by Acoustica Associates, Inc., Mineola, L.I., N.Y., and marketed nationally by American Hospital Supply Corp., Evanston, Ill.

For more details circle #186 on mailing card.

## Ohio Nebulizer Employs Tubing Reducer

The new Ohio Nebulizer employs a special tubing reducer to permit use with either small, smooth bore or large corrugated inhaler tubing. The nebulizer may be attached directly to a flowmeter or to supply tubing leading from a wall outlet. It generates particles in the effective therapeutic range of .5 to 3.0 micra at flow rates as low as 3 l.p.m. Flow rates as high as

(Continued on page 176)

15 l.p.m. may be had at normal pipeline pressure. A warning whistle tells of any obstructions in the outlet tubing throughout the complete flow rate range. The Ohio Nebulizer may also be used as a humidifier when water is placed in it. It has a non-breakable plastic bottle and body of non-corrosive metals. Ohio Chemical & Surgical Equipment Co., Madison 10, Wis.

For more details circle #187 on mailing card.

## Institutional Package for Campbell's Soups

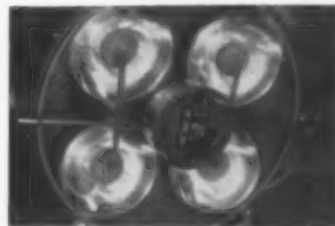
The institutional 50-ounce size is now available in the three new soups recently introduced by Campbell-Turkey Noodle, Chicken Vegetable and Minestrone. This brings to 18 the number of soups available in the 50-ounce condensed size. The three new soups are hearty and nourishing, yet can be served at moderate cost with minimum preparation time. Campbell Soup Co., Camden, N.J.

For more details circle #188 on mailing card.

## Camera Attachment for Surgical Record

The Castle Camera Attachment, designed to be mounted in the lamphead of any Castle "60 Series" light, provides a practical method for permanent recording of surgical procedures on film. It is adapted to house a standard Kodak IIIc 35mm camera and to take pictures in either black and white or color.

The area to be photographed and proper camera distance are established by means of two rangefinder lights built into the camera attachment. Shutter speeds and aperture are pre-set, one central knob winds the film and cocks and trips the shutter for exposure. Operation is simple and double exposures are impossible as the



camera cannot be cocked until the exposed film has been wound into position. Pilot lights indicate when exposure is complete, and dual controls permit operation of the camera from either side of the lamp head outside the sterile zone. Wilnot Castle Co., 1905 E. Henrietta Rd., Rochester, N.Y.

For more details circle #189 on mailing card.

## WHAT'S NEW



### Stainless Steel Hand Sink for Food Preparation Areas

Designed to comply with health regulations requiring installation of hand washing sinks in areas where food is prepared or dispensed, the new Seco Stainless Steel Hand Sink is available in two models, 11 by 15 by 6 inches and 15 by 20 by 6 inches in size. The die-stamped stainless steel bowls are one-piece, fully coved and furnished complete with chrome plated combination hot and cold faucet with gooseneck spout, strainer type waste, chrome plated tail piece, chrome plated "P" trap with cleanout cap, and bracket for wall mounting. Seco Company, Inc., 4560 Gustine Ave., St. Louis 16, Mo.

For more details circle #190 on mailing card.

### Food Waste Disposer Works at High Speed

The Colerain Red Goat Food Waste Disposer is a heavy duty unit with a high-speed disintegrating action for all types of food waste. It is constructed to meet all sanitation and plumbing codes. Easy to install, the Red Goat has a large opening for easy feeding, rugged cast-iron and alloy-steel construction, synchronized automatic motor and water controls and a new disintegrating principle. It is designed for heavy-duty institutional and commercial use and is automatic in operation. The Colerain Metal Products Co., 2021 Eastern Ave., Cincinnati 2, Ohio.

For more details circle #191 on mailing card.

**1. BACTERICIDAL**  
when diluted with water  
(except the tubercle bacillus)

**ALSO**

**2. TUBERCULOCIDAL**  
when diluted with alcohol



B-P INSTRUMENT CONTAINER  
No. 300

Ideal for use with Bard-Parker  
HALIMIDE—stainless steel and  
PYREX glass with airtight cover.

BARD-PARKER

## HALIMIDE®

a CONCENTRATE for  
inexpensive instrument  
disinfection

HALIMIDE—a recently developed non-staining, clear CONCENTRATE of low surface tension and excellent penetrating qualities, is scientifically perfected for inexpensive instrument disinfection... 1 oz. makes 1 gal. of NON-CORROSIVE (No anti-rust tablets to add) STABLE (need not be changed frequently) solution.

LIST PRICE—4 oz. bottle ..... \$2.90  
Available in quarts and gallons

See your DEALER for quantity discounts

PARKER, WHITE & HEYL, INC.  
Danbury Connecticut

### Adaptic Packing Strips Are Non-Adhering

A revolutionary type of packing strip is offered in the new Adaptic Non-Adhering Packing Strips since drainage passes through the mesh of the non-absorbent coated fibers and does not coagulate. The packing strip can thus be removed without pain to the patient or damage to tissue. The new strips conform to body contours, thus giving uniform packing pressure. The new Non-Adhering strips are available in one-half, one



and two-inch widths, all four yards long. Johnson & Johnson, Hospital Div., New Brunswick, N.J.

For more details circle #192 on mailing card.

### Odorless Interior Paint Is Fast-Drying

Merplax is a new development in acrylic-vinyl latex paint for interior use. The result of months of intensive research, the new paint is odorless, requires no thinner, is self-priming, with excellent hiding qualities, and dries in thirty minutes. Rooms can thus be painted and ready for use almost as soon as the painters are out.

The new Merplax paint can be applied by brush, roller or spray gun and spots can be touched up as it does not streak and applies evenly. Paint brushes and rollers used to apply Merplax can be thoroughly cleaned immediately after use by rinsing in warm water, yet the paint has excellent washability. Merplax can be used on new or painted plaster, woodwork, wall-board, interior brick and other masonry surfaces, and wall papers. It is available in a variety of decorator colors. The M. J. Merkin Paint Co., 1441 Broadway, New York 18.

For more details circle #193 on mailing card.

(Continued on page 178)

ALL BARD-PARKER SOLUTIONS CONSERVE THE BUDGET DOLLAR



**SPRING  
BONUS**



**TWO BOXES  
(1000 FLEX-STRAWS)  
FREE!**

*in every case purchased*

**APRIL AND MAY ONLY**

*for use in both  
hot and cold liquids*

*Each case of 10,000 (20 boxes)  
Billed as 9,000 (18 boxes)*

**BENDS TO ANY ANGLE**

*safe  
sanitary  
disposable*

**PATENTED  
FLEX-STRAW®**  
2040 BROADWAY SANTA MONICA, CALIF.

**LIST PRICE TO HOSPITALS**

**UNWRAPPED**  
10 M (1 case) 4.50 per M  
4 cases or over 3.95 "

**INDIVIDUALLY WRAPPED**  
10 M (1 case) 5.40 per M  
4 cases or over 4.75 "

*Unwrapped Flex-Straws now packed  
in convenient disposable dispenser  
boxes, as illustrated.*

**OFFER EXPIRES MAY 31, 1958 • ORDER FROM YOUR DISTRIBUTOR NOW!**

## WHAT'S NEW

### Cerva-Crane and Halter for Effective Traction

Effective and comfortable traction therapy can be easily applied with the two new Zimmer traction devices. The Cerva-Crane quickly and easily attaches to almost any straight chair by a versatile clamping system. It provides a rigid support for a traction lever operating on an almost frictionless pivot. A simple locking lever permits adjustment of the Cerva-Crane for the height of the patient.

The Tracto-Halter is a new form of head halter providing increased patient comfort with excellent therapy since higher forces can be more readily tolerated. The con-



tours of the Tracto-Halter apply force to the occiput for efficient traction to the cervical spine without uncomfortable pressure on chin and cheekbones. The specially contoured chin-piece is of a sandwich-type construction consisting of a lustrous base of stabilized Dacron yacht duck to which nylon web hanging straps are attached with a layer of resilient foam to increase comfort and distribute uneven loads. Tracto-Halters are completely washable, dry quickly, and have only one strap for easy adjustment. Zimmer Mfg. Co., Warsaw, Ind.

For more details circle #194 on mailing card.

### Vinyl Asbestos Flooring Is Fire Retardant

The new Kentile Fire Retardant Vinyl Asbestosile flooring is the result of years of experiment and testing. The manufacturer states that the new Fire Retardant Tile meets rigid government specifications and is suitable for use in schools, colleges, hospitals and other institutions.

Produced in .080 thickness in regular nine by nine-inch tiles, the flooring is available in black with white marbleizing, white with red and black mottling, red with white marbleizing, green with white marbleizing, white with black marbleizing, and tan with brown and white mottling. The new tile is durable and easy to install and maintain. Its smooth, non-porous surface resists dirt and grease and retains its luster and beauty indefinitely. Kentile, Inc., 58 Second St., Brooklyn 15, N.Y.

For more details circle #195 on mailing card.

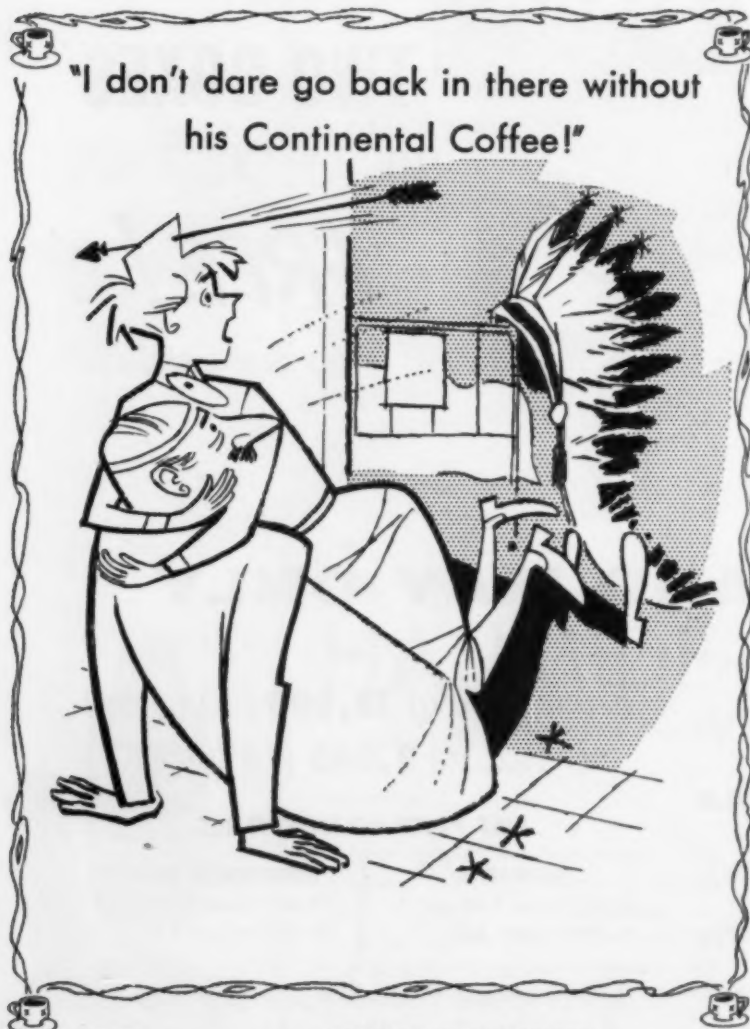
### Poison Antidote Cart Is Mobile Unit

A poison-control center is available for immediate use in the hospital with the new Continental Poison Antidote-Mobile Unit. Designed for use in the emergency room, the mobile unit can be readily moved to



rooms or wards as required. It is constructed of heavy steel with compartments, shelves and slots for instructions, references and all known antidotes and equipment for treatment of poison cases, saving time and trouble. All antidotes are in one convenient location, ready for immediate use, with an optional locking arrangement. The unit is 36 inches wide, 18 inches deep and 41 inches high and has rubber casters for easy mobility. Continental Hospital Industries, 18624 Detroit Ave., Cleveland 7, Ohio.

For more details circle #196 on mailing card.  
(Continued on page 180)



"I don't dare go back in there without  
his Continental Coffee!"

Write for free trial package

**Continental Coffee**

AMERICA'S LEADING COFFEE  
for Restaurants, Hotels and Institutions  
CHICAGO • BROOKLYN • TOLEDO • SEATTLE



**YOURTOWN MEMORIAL HOSPITAL**

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*Charges completely described and listed by date of service.*

DATE	CHARGE DESCRIPTION	TOTAL	PAID BY	CHARGED TO	DATE
MO.	DAY				
<b>GROUP HLTH AND ACCIDENT</b>					
918	ELECTRO CARDIOGRAM	15.00	15.00		
918	COMPLETE BLOOD COUNT	5.00	5.00		
918	OXYGEN	5.25	5.25		
918	ROOM AND BOARD	22.00	15.00	7.00	
919	ROOM AND BOARD	22.00	15.00	7.00	
919	X RAY CHEST	15.00	8.75	6.25	
919	DRUGS	5.00	5.00		
919	OXYGEN	5.25	5.25		
920	ROOM AND BOARD	22.00	15.00	7.00	
920	DRUGS	1.10	1.10		
920	DRUGS	1.10	1.10		
921	ROOM AND BOARD	22.00	15.00	7.00	
921	OXYGEN	5.25	5.25		
921	DRUGS	1.10	1.10		
922	ROOM AND BOARD	22.00	15.00	7.00	
922	WHITE BLOOD COUNT	2.00	2.00		
922	DRUGS	1.10	1.10		
923	ROOM AND BOARD	22.00	15.00	7.00	
923	OXYGEN	5.25	5.25		
924	ROOM AND BOARD	22.00	15.00	7.00	
924	DRUGS	1.10	1.10		
925	ROOM AND BOARD	22.00	15.00	7.00	
925	ELECTRO CARDIOGRAM	15.00	15.00		
926	ROOM AND BOARD	22.00	15.00	7.00	
927	ROOM AND BOARD	22.00	15.00	7.00	
928	ROOM AND BOARD	22.00		22.00	
		322.60	185.00	137.60	

*X-ray charge split automatically.*

*Room and board limit recognized and charges appropriately split.*

*Separate totals for patient and third party.*

PAY THIS AMOUNT ↑

# IBM PATIENT BILLING

## distributes third-party charges automatically

Swift, automatic distribution of charges between patients and third-party guarantor—this is only one of the many ways IBM in-patient billing systems help you serve patients better.

### OTHER BENEFITS:

- Itemized and legible bills.
- Accurate, detailed revenue breakdowns and up-to-the-minute expense reports.

- Automatic accounts-receivable control.
- Swift and easy preparation of aged trial balance.

Find out how IBM can modernize your accounting operation. Get the complete facts from: HOSPITAL DEPARTMENT A58a, International Business Machines Corporation, 590 Madison Avenue, New York 22, New York.

DATA PROCESSING • ELECTRIC TYPEWRITERS

**IBM**

**DATA  
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TIME EQUIPMENT • MILITARY PRODUCTS

## WHAT'S NEW

### once a luxury NOW A NECESSITY IN THE MODERN mass-feeding KITCHEN



### Machine Washing

- POTS
  - PANS
  - UTENSILS
- with an

### A-F "PANHANDLER"

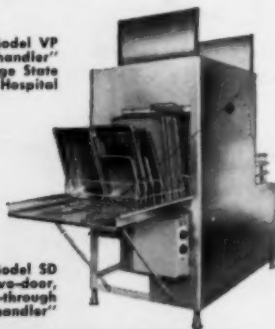
Today, an A-F "Panhandler" completely automatic Pan and Utensil Washer is as necessary as a mechanical dishwasher.

Washing time for mixing bowls, cooking utensils, steam table pans, food transport containers . . . even garbage pails . . . is greatly reduced over other methods—and the operator is free to do other jobs during the automatic "wash-drain-rinse" cycle. Because it operates at an elevated temperature, an A-F "Panhandler" not only washes thoroughly and uniformly—but sanitizes!

Two compact models are available to fit any kitchen. Either can be supplied for steam, gas or electric heating.

Write for new folder—today.

TOP—Model VP  
"Panhandler"  
at large State  
Mental Hospital



RIGHT—Model SD  
two-door,  
pass-through  
"Panhandler"

### THE ALVEY-FERGUSON CO.

215 Disney Street, Cincinnati 9, Ohio  
Representatives—Coast to Coast

### Steam Cookers and Kettles in Combination

Four new Steam-Chef Super Generator Type Steam Cookers were recently introduced. Operated by gas or electricity, the Super Generator steamers are available separately or as a combination unit with



steam kettles, as illustrated. They are available in two, three and four-bushel sizes with stainless steel or aluminum kettles. The steam cookers are easily cleaned, attractive and designed to meet the most discriminating sanitation requirements. The Cleveland Range Co., 3333 Lakeside Ave., Cleveland 15, Ohio.

For more details circle #197 on mailing card.

### Stylon Ceramic Floor Tile in Large Squares

Stylon "Crystal-Glazed" ceramic floor tile is now available in large 12 by 12-inch tiles. The attractive, durable flooring is frostproof and can be used indoors or out, according to the report. It provides a permanent, wearproof flooring and is offered in fifteen colors. Stylon Corporation, Milford, Mass.

For more details circle #198 on mailing card.

### Internal Filter Machine in Heavy Duty Vacuum Cleaners

The new 300 Series Heavy Duty Tornado Vacuum Cleaner is a quiet type internal filter machine which can be used for wet or dry pickup. Increased air volume is supplied by a one h.p. motor and a new three-stage fan. The 300 can be used with



1½ or two-inch hose and has a top air speed of 375 m.p.h. The electric cable is detachable from the motor for convenience in storing and replacement. Two types of wheels are available, one of which permits moving the machine up or down stairs or over cables and hose without difficulty. Breuer Electric Mfg. Co., 5100 N. Ravenswood Ave., Chicago 40.

For more details circle #199 on mailing card.

(Continued on page 184)

### AGENTS WANTED



Make  
Quick  
Sales,  
Good  
Profits  
with...

**Ped-O-Flo**  
FOOT OPERATED  
LIQUID SOAP DISPENSER

Every doctor, every dentist, every hospital a prospect. Low unit cost makes it possible to install a PED-O-FLO dispenser at every scrub sink and lavatory. Meets the most rigid requirements of surgical asepsis. Unconditionally guaranteed for one year.

ANASEP G 11 SURGICAL LIQUID SOAP  
REFILLS ASSURE YOU REPEAT BUSINESS  
Choice territories open—write for details.

PECK'S PRODUCTS COMPANY  
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### HOSPITAL PLAQUES

and signs for every purpose in  
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THE OPERATING UNIT  
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Hospitals from coast to coast have gotten the best for less because of our unsurpassed facilities and years of nationwide experience. It will pay you to look over our new catalog, prepared especially for our increasing clientele in the hospital field. Why not send for it today...now!



Room and Door Plaques  
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**UNITED STATES BRONZE  
SIGN CO., INC.**

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Plant at Woodside, L. I.

The MODERN HOSPITAL

## Follow the lead of these outstanding hospitals



**Cardinal Glennon Memorial Hospital for Crippled Children, St. Louis**  
MAGUOLO & QUICK, Architects and Electrical Engineers.  
S. C. SACHS COMPANY, INC., Electrical Contractor.



**Continued Treatment Building of Norwich Hospital, Norwich, Conn.**  
WALTER P. CRABTREE, JR., Architect. HOWARD W. HARPER,  
Electrical Engineer. EALAHAN ELECTRIC CO., Electrical Contractor.



**Fairview Park Hospital, Cleveland**  
GARFIELD, HARRIS, SCHAFER, FLYNN & WILLIAMS, Architects.  
BYERS, URBAN, KLUG & PITTENGER, Consulting Electrical Engineers.  
HARRINGTON ELECTRIC CO., Electrical Contractor.



**Holy Cross Hospital, Fort Lauderdale**  
STEWART & SKINNER, Architects. M. H. CONNELL & ASSOC.,  
Electrical Engineers. E. C. CORNELIUS, Electrical Contractor.

## ...call Day-Brite for the facts and the fixtures!

Each of these hospitals required the highest standards of lighting performance adapted to specific areas and functions. Each demanded equipment that was easy to maintain. Fixtures built to endure frequent cleanings and long hours of continuous operation. They each got the lighting facts... and decided on Day-Brite fixtures.

Planning to light or relight your hospital? Call your Day-Brite representative, listed in the Yellow Pages. Or write Day-Brite for illustrated booklet on hospital lighting.



Day-Brite Lighting, Inc., 6280 N. Broadway, St. Louis 15, Mo.  
Day-Brite Lighting, Inc., of Calif., 530 Martin Ave., Santa Clara, Calif.

Z-133

**NATION'S LARGEST MANUFACTURER OF COMMERCIAL AND INDUSTRIAL LIGHTING EQUIPMENT**

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**50% MORE**  
USEABLE SPACE



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**STA-KOLD® • SNO-QUEEN®**  
ALL-METAL REFRIGERATORS

the only space that really counts is the  
**SPACE YOU CAN USE—**  
**YOU CAN USE ALL THE SPACE**  
in these refrigerators

Exclusive roller bearing pull-out shelves permit easy access to items stored in the rear. This eliminates dead overhead shelf space and allows much closer shelf spacing. With our pan slides you can now use the areas that used to be "hard-to-reach". There's a model for every need, a size for every use, a price for every budget.

**YOU CAN CHANGE  
THE INTERIOR IN  
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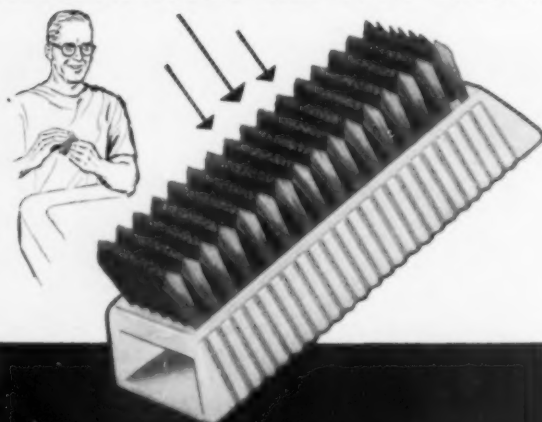
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**SURGEON'S BRUSH**

- 112-lifetime tufts anchored in non-corrosive nickel silver
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- tufts are soft but firm and especially tapered for better scrub-up efficacy with more comfort
- grooved handles assure firmer grip... crimped bristles retain soap better

Satisfied users are one of your hospital's best assets, so why not please your surgeons by getting the best. Outstanding performance also makes Anchor brushes the most economical on the market today.

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HOSPITAL SUPPLY FIRM

OTHER HIGH QUALITY ANCHOR PRODUCTS...

NEW, All-Nylon Emesis Basin  
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Sold Only Through Selected Hospital Supply Firms.

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## Does your Ethyl Alcohol supplier offer your Pharmacy all these advantages?

Dependable service from U.S.I.'s nationwide chain of bonded warehouses eliminates the need for excessive alcohol stocks, solves inventory and storage problems, is your most reliable source in case of emergency

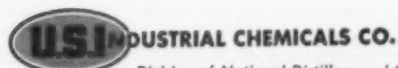
The first requirement the pharmacist would set for ethyl alcohol is *purity*. But once the U.S.P. requirement is met (or exceeded, as it is with U.S.I. alcohol) he would add another qualification: *Service*.

Dependable delivery from a nearby source means the pharmacist doesn't have to keep excessive stocks on hand as a precaution against delayed deliveries. This in turn simplifies his inventory control records. His storage problems are

minimized, yet he knows that the once-in-a-million call for emergency supplies of alcohol will be answered . . . immediately.

U.S.I. offers that kind of service. America's oldest producer of hospital and industrial alcohol, U.S.I. has nine bonded warehouses across the country. Its sales organization has been serving hospitals for half a century.

For your pure alcohol needs, specify U.S.I. — get purity and service.



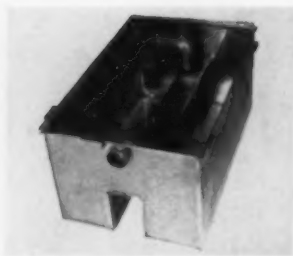
**INDUSTRIAL CHEMICALS CO.**  
Division of National Distillers and Chemical Corporation  
99 Park Avenue, New York 16, N. Y.  
Branches in principal cities

*U.S.I. pure alcohol U.S.P.* 

## WHAT'S NEW

### Sanitary Interceptor Cuts Maintenance Costs

Designed and built by a sanitary inspector who knows the problems of grease interception, the new Sanitary Interceptor can be installed inside or outside a building and is simple and easy to operate. Installed below the water and grease line, the new unit has a grease capacity of 58 pounds. Made of heavy gauge non-corrosive stainless steel with standard copper and brass fittings, it is opened by a flip of the catch for easy and quick cleaning. Interceptors with larger capacities are also available. They have no baffles or moving parts and operate on a new principle of



grease interception for efficiency and easy maintenance. **Sanitary Interceptor Sales, 2060 McGregor Blvd., Fort Myers, Fla.** For more details circle #200 on mailing card.



### NEW MEDI-PREP MEDICINE STATION

Nursing efficiency starts here with the new Market Forge **MEDI-PREP**. Everything is readily at hand in this compact, all-stainless steel unit combining a roomy, well-lighted storage cabinet with refrigerator, sink and ample working space. You also will appreciate the separately locked narcotics compartment, convenient pillbox shelves and waste facilities.

Write today for detailed specifications and information on how the new **MEDI-PREP** can help save considerable nursing time and effort at modest cost. **WRITE DEPT. MH-4**

**MARKET FORGE CO.**  
EVERETT 49, MASS.



### Medical Records Folders Employ Color Keys

Color bands are printed on the new Color-Keyed Terminal Digit Filing Folders, thus eliminating the time required to apply colored tapes. Keyed to specific groups of terminal digits, the distinctive colors speed both filing and finding. The colors also assist in preventing mis-filing since an odd color in a red area, for instance, would be immediately noticed.

Of medium heavy weight, high quality Duratex, the folders are 11½ by 9½ inches in size and the straight cut tabs project ¾ inch and are double weight for extra durability. The color bands are printed on the right margin and on the front and back of the upper right corner. Folders are packed 100 of one color to a box. **Physicians' Record Co., 161 W. Harrison St., Chicago 5.**

For more details circle #201 on mailing card.

### "Surgiderm" Surgeon's Glove Reduces Hand Fatigue

Hand fatigue is said to be reduced by requiring 24 to 30 per cent less energy to flex the fingers and hands with the new "Surgiderm" surgeon's gloves. The report



states that the new gloves are now in production and combine softness, comfort and reduced hand fatigue with strength and aging qualities. The gloves are soft and comfortable, yet provide the necessary strength and sensitivity. **The B. F. Goodrich Co., Akron, Ohio.**

For more details circle #202 on mailing card.

### Explosion-Proof Switches for Electronic Equipment

Engineered for the operation of electrical and electronic equipment in hazardous areas, the two new explosion-proof foot-switches introduced by Birtcher have all electrical contact points sealed into a cast aluminum housing to conform to Underwriters specifications. A double-pedal type with three-wire plug is available in switch No. 760-T which is designed to fit existing outlets on Birtcher 799-H and 2000 surgical units. The single pedal No. 761 is intended for use with Birtcher Defibrillator, Blendtone and similar equipment. The switches have 12-foot flexible type S cords with locking Cannon connectors and receptacles and can be used on any electrical or electronic equipment of the same voltage and amperage as Birtcher units. **The Birtcher Corp., 4371 Valley Blvd., Los Angeles 32, Calif.**

For more details circle #203 on mailing card.

(Continued on page 186)



**THERE IS NO OTHER**

**Heating Method  
that offers so much more  
in comfort conditioning**

**The  
BURGESS-MANNING  
Radiant Acoustical  
Ceiling**

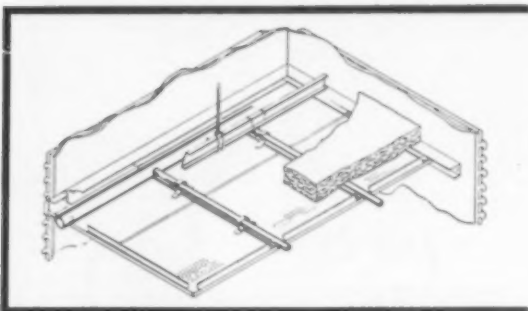
**The Only Completely Integrated  
Radiant Heating, Cooling and  
Acoustical Ceiling**

True Radiant Heat is proved to be closest to the ideal, the more technically correct method, of any known means of heating for human comfort. Now, Burgess-Manning has made it possible and practical for use in hospital buildings.

The Burgess-Manning Radiant Acoustical Ceiling provides not only highly efficient and healthful radiant heating, but, where desired, Radiant Cooling as well, plus a most efficient acoustical control.

With the heating element in the ceiling, all floor space is useful—no costly space occupied by old style radiators or heat distributing devices. Radiant heating is the cleanest method known—it eases maintenance problems and saves maintenance costs.

Write for Burgess-Manning Catalog 138-2M



But the greatest advantage that Burgess-Manning Radiant Acoustical Ceilings bring to hospital buildings is the healthier, more comfortable atmosphere it brings to your patients!

*Remember*

**Your Building is Better  
Your Building Budget No Bigger**



**BURGESS-MANNING COMPANY**

*Architectural Products Division*  
5970 Northwest Highway, Chicago 31, Ill.

## WHAT'S NEW

### Blood Donor Couch Affords Comfort and Relaxation

The Sera-Sofa is a unique three-position couch for blood donors, designed for comfort and relaxation. It is designed to improve psychological reactions by putting



the donor at ease in a relaxed position. It supplies convenient mounting and working height without the use of foot stools and facilitates work of the technician. The Sera-Sofa adjusts quickly and easily to the positions for preparation, donation and a third position should the donor feel faint. The overall dimensions require minimum space. The MacBick Co., 243 Broadway, Cambridge, Mass.

For more details circle #204 on mailing card.

### Shadowal Block for Attractive Walls

Representing an interesting departure from ordinary concrete block, Shadowal Block has a pattern already built into its surface. When laid together in a wall,

Shadowal Blocks form a virtually limitless number of attractive designs with three-dimensional effect. A new concept in exposed masonry construction, the blocks permit the development of decorative walls at little extra cost. Made with a three-eighths inch angled recess in the face of a modular eight by eight by sixteen-inch block, an interesting network of shadows is cast when light falls on the indented area.

Large wall expanses can be broken up with attractively patterned sections requiring little maintenance. Shadowal Block is durable, firesafe, sound absorbent and requires no finishing. If desired, however, it can be coated with transparent waterproofing or painted in a variety of colors. The National Concrete Masonry Association, 38 S. Dearborn St., Chicago 3.

For more details circle #205 on mailing card.

### White Plastic Pocket Protects Uniforms

An attractive white plastic pocket shield is now available for lining pockets of uniforms for nurses, interns, doctors and others wearing white. The plastic is formed into a pocket for pens, pencils, thermometers and other items. A flap holds it in place and an extra pocket at the bottom holds change for telephones, papers and other miscellaneous items. Designed to slip inside a regular uniform pocket, the plastic lining protects uniforms from lead and ink stains and from soil. Zie-Dei Enterprises, 4551 N. Clark St., Chicago 40.

For more details circle #206 on mailing card.

### Margarine for Baking Has Special Flavoring

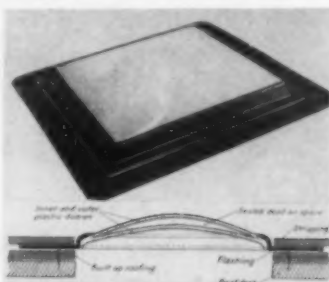
A closely controlled cultured milk flavoring process is used in the new Kraft Bakers' Colored Vegetable Oleomargarine recently introduced. Flavor intense enough to survive baking temperatures is incorporated without the use of artificial flavoring agents. The yellow color improves the appearance of finished products as the new flavoring process improves their taste. The new Bakers' Margarine is packed in 30-pound tins. Kraft Foods Co., 500 Peshtigo Court, Chicago 90.

For more details circle #207 on mailing card.

### Minimum Heat Transfer With Consolite Skylight

Heating and air conditioning losses are greatly reduced with the new Consolite Skylight. The twin-domed all-plastic skylight has a "thermos bottle" type construction. The dead air space between the sealed inner and outer domes acts as an efficient insulator, keeping heat in and cold out in cold weather and the reverse in hot weather.

Consolite Skylights are formed completely of fiberglass reinforced structural plastic, making it light in weight, easy to install, but extremely strong. The self-flashing model illustrated is designed for



long, maintenance-free usefulness. The cross-section drawing illustrates the construction and the light transmission without significant heat transfer which also eliminates interior condensation. Resolite Corporation, Zelienople, Pa.

For more details circle #208 on mailing card.

### Power Roof Exhauster Features Quiet Operation

The new Gyra-Flo Power Roof Exhauster is designed to control the flow of air, keeping turbulence and discharge losses to absolute minimum and providing noiseless operation. It is designed for ventilating hospitals, schools and other institutions where roof ventilation is applicable. The wheel of the belt-driven unit is of the backward curve type, featuring steep pressure curves and non-overloading power characteristics, resulting in quiet operation. It is constructed of stainless steel or other alloys, depending upon specific requirements, and the base is floated at four points on rubber to diminish magnetic hum and vibration. The entire unit is designed for easy maintenance. Chicago Blower Corp., 9863 Pacific Ave., Franklin Park, Ill.

For more details circle #209 on mailing card.

(Continued on page 188)

*pays  
its  
way...  
day by day!*



Cat. No. 8396

### the new STANLEY WINDSOR unbreakable beverage server

Serve it hot. Serve it cold. And never again worry about breakage costs! The new Stanley Windsor is gleaming stainless steel inside and out. It's built to last a lifetime. The Windsor comes with a new thumb-lift hinged lid, an oversize stay-cool handle and large non-drip pouring lip. Write us today for full information. You'll be amazed at the low, low price.

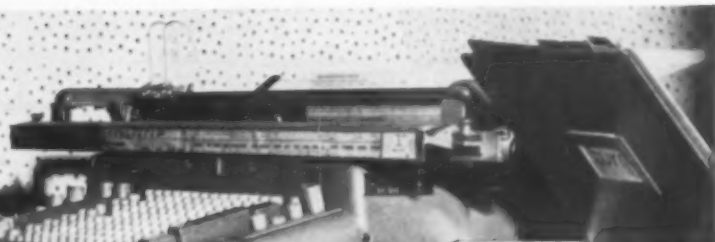
STANLEY INSULATING DIVISION Landers, Frary & Clark, New Britain, Conn.



THIS NATIONAL ACCOUNTING MACHINE posts all bookkeeping work with maximum speed and efficiency.



THE ULTRA-MODERN Long Beach Osteopathic Hospital in Long Beach, California.



A. E. WIGDAHL, Business Manager of the Long Beach Osteopathic Hospital, Inc.

"Our *National* System  
saves us \$625 a month...  
repays equipment cost every 10 months!"

—Long Beach Osteopathic Hospital, Inc., Long Beach, California

"We recently installed a National System in our bookkeeping department," writes A. E. Wigdahl, Business Manager of the Long Beach Osteopathic Hospital, Inc. "By simplifying our operating procedure, our National greatly reduces record-keeping expenses for us.

"Our National System handles all of our accounting with speed and efficiency, eliminating costly overtime. Yet our accounts are always up-to-date, and statements are ready

for patients when they are dismissed from the Hospital. And since Nationals are so easy to operate, it's easy to train new employees.


"Our National System saves us more than \$625 a month, repays the equipment cost every 10 months!"

*A. E. Wigdahl*

Business Manager of the  
Long Beach Osteopathic Hospital, Inc.

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Your hospital, too, will benefit from the time- and money-savings made possible by a National System. Nationals pay for themselves quickly through savings, then continue to return a regular yearly profit. For complete information, call your nearby National representative today. He's listed in the yellow pages of your phone book. 

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**National**

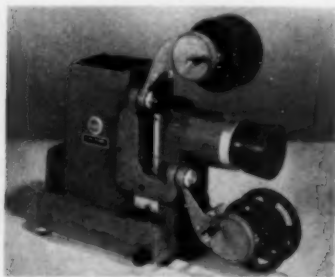
ACCOUNTING MACHINES

ADDING MACHINES • CASH REGISTERS

NCR PAPER (NO CARBON REQUIRED)

## WHAT'S NEW

### X-Ray Projector Permits Any Magnification



The Atlantic X-Ray Projector is a 35mm

x-ray microfilm reader-projector permitting any degree of magnification desired for the reading of x-ray microfilm. It produces a brilliant image permitting the distinguishing of all fine tonal gradations. It can be used for individual comparisons and studies or for large-audience viewing for teaching.

Model XA, complete with carrying case, has a 500-watt projection lamp with a blower to keep the lamp cool. The film passes over smooth idler rollers and between easily removed glass flats which keep the image constantly in focus. The projector is an adaptation of the Kodak Signet Projector with high quality construction throughout. Atlantic Microfilm Corp., Pearl River, N.Y.

For more details circle #210 on mailing card.

### Bardic Disposable Line of Transparent Polyvinyl

Transparent polyvinyl plastic is used to form the entire line of Bardic disposable plastic products. Designed to meet modern hospital requirements for inexpensive, dependable items that will save time and reduce the danger of cross-infection, the new line reduces labor costs and increases efficiency. Bardic tubular products are inert and will not react to body chemicals. The large lumen tubing has a satin smooth surface and resists kinking. C. R. Bard, Inc., Summit, N.J.

For more details circle #211 on mailing card.

### Room Air Conditioners in Space-Saving Size

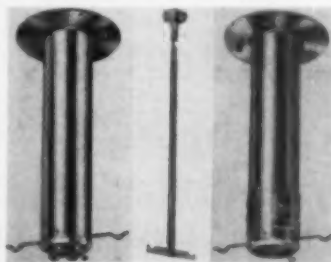
Compactness is the primary feature of the four new room air conditioners introduced by Trane. Minimum installation space is required with the new units. The new models include a low 12-inch vertical cabinet for installation beneath low sills, a 12-inch vertical unit for concealed installation at floor level, a 10-inch deep horizontal cabinet model for ceiling installation and a 10-inch horizontal unit for concealed installation above ceilings.

Designed to maintain exact comfort conditions under varying sun, artificial light and occupant load situations, the new units are used for perimeter air conditioning in high velocity induction central systems. Individual control is automatic or manual, as desired, and complete air conditioning is provided, including filtering, temperature, humidity and ventilation controls. The Trane Company, La Crosse, Wis.

For more details circle #212 on mailing card.

### Overhead Services Save Floor Space

A new Logan Intravenous Equipment Support, a new Overhead Electrical Unit, and a redesigned Overhead Surgical Gases Dispenser unit were recently introduced.



Designed to clear floor areas in surgical and recovery rooms for other uses, the three new products combine convenience and efficiency. The overhead location facilitates safety and free movement of equipment on the floors and permits quick connection overhead.

Simple exterior forms are features of the overhead units in addition to concealed piping with supplies in remote locations, service at convenient points of use and attractive, sturdy construction. All units are formed of brass, chrome plated. Logan Hospital Equipment Co., P.O. Box 751, Glendale, Calif.

For more details circle #213 on mailing card.

(Continued on page 190)

# DUNDEE

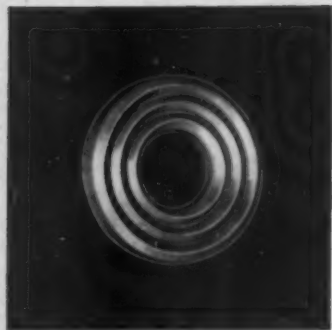
## EXCLUSIVE FEATURES



Dundee's extra-wide SUPER-SELVAGE provides greater tensile strength than other hemmed or turned selvages... eliminates puckering and possible retention of washing-chemicals. The wide CAM BORDER permits better property marking. And remember, when you specify Dundee... your linen source *knows* you're particular!

**DUNDEE MILLS, INC., GRIFFIN, GEORGIA**

Showrooms: 40 Worth Street, New York, N. Y.



**a gas tight system is only  
as good as its *Washer!***

The most modern equipment, plus the purest gas, plus perfect mechanical order are not enough if the cylinder connection washer does not prevent leaking.

The new Puritan silver tone valve washer now enables all cylinder connections to be made leakproof—and stay leakproof—with just minimum tightening.

Only because of the development of a new especially molded material is this important advancement in valve washer performance possible.

**P**uritan   
COMPRESSED GAS CORPORATION  
SINCE 1913  
KANSAS CITY 8, MO.  
PRODUCERS OF MEDICAL GASES  
AND GAS THERAPY EQUIPMENT

# Meinecke

helps you serve  
more patients, better

- NO BED-JARRING BUMPS
- NO NICKED, MARRED WALLS
- LOWER REDECORATING COSTS



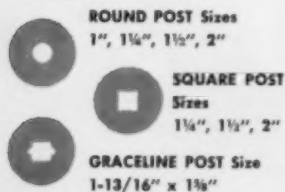
Armstrong-Stedman  
Molded Rubber

## BED BUMPERS

- absorb shock, add to patient comfort
- maintain "good housekeeping" appearance
- protect your investment in wall finishes, woodwork and furnishings

Tough, resilient, smudge-proof, they simply slip around each leg of any hospital bed. Bolt and nut embedded in the specially compounded rubber fasten them in place quickly and easily. Small in cost, they start paying for themselves the day you install them!

Standard 5" outside diameter affords all-round protection. Select type and inside size from these convenient diagrams:



All in rich walnut color.

Lots of 6 doz. .... \$20.50 doz.  
Lots of 3 doz. .... 21.55 doz.  
Smaller lots ..... 22.40 doz.

Prices in larger quantities on request

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65 years of continuous service  
to the hospitals of America  
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419 Gadsden St. • Columbia • S.C.  
9012 Sovereign Row • Dallas 19 • Tex.  
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Los Angeles 21 • Calif.

## WHAT'S NEW

### Year 'Round Unit for Room Air Conditioning

Available in cabinet or recessed models, vertical or horizontal, with combination cooling and heating coils, combination di-



rect expansion and steam coils, and three control kits, the new CR is a versatile year 'round room air conditioning unit. Summer cooling and winter heating are equally effective. Variety in choice of construction and type and manner of installation are features of the unit. Dunham-Bush, Inc., 179 South St., West Hartford 10, Conn.

For more details circle #214 on mailing card.

### Self-Contained Electric Plants are Economically Priced

Savings in cost with dependable efficiency are stressed as features of the new HC Series of water-cooled, revolving-armature Onan 10 and 15 KW electric plants. Available in 10,000 or 15,000 watt A.C. size ranges, the new series is completely self-contained. Full-rated electric power for all types of standby emergency applications is provided by the gasoline-engine-driven units. D. W. Onan & Sons Inc., 2515 University Ave. S.E. Minneapolis 14, Minn.

For more details circle #215 on mailing card.

### Versatile LECTERN-LITE Prevents Light Leakage

Adequate light is provided for the speaker without any light leakage to distract the audience with the new LECTERN-LITE recently introduced. Designed for use on lecterns in large rooms, the new light has an easily adjustable reflector and a special green panel to prevent glare. Conveniently



portable, the light may be attached permanently if desired. It utilizes two regular 25-watt or 40-watt bulbs and has rubber protected edges. The new LECTERN-LITE can also be used for pianos, organs and music stands. Faries Lamp Division, General Lamps Mfg. Corp., Elwood, Ind.

For more details circle #216 on mailing card.

### Adjustable Packless Valve for Improved Control

A new four-inch Powertop pneumatic valve is introduced for improved control of unit conditioners, unit ventilators and convectors. The corrosion-proof, adjustable packless valve incorporates several features which increase its adaptability, accuracy and length of service. The new Monel externally adjusted and easily accessible spring permits variable top pressure, enabling a single valve to meet a variety of conditions. The lower housing on the new valve is made of high impact phenolic, eliminating electrolytic corrosion. The large silicone diaphragm provides greater closing power. Other features give the new Powertop valve increased efficiency in operation. The Powers Regulator Co., 3434 Oakton St., Skokie, Ill.

For more details circle #217 on mailing card.

### Kodak Analyst II Projector for Time-Motion Study

Developed for the radiologist doing cinematography, the new Kodak Analyst II Projector with Weinberg-Watson Modification is applicable for time-motion studies



using 16mm film. The projector has a variable projection speed from six to 20 frames per second, instant single frame viewing by remote control push button, reverse motion and flickerless projection. Excellent viewing is assured and 16mm film of any length up to 400 feet can be projected. The special cooling system protects films and refocusing is not required. The projector is simple and convenient for table top viewing but is also provided with a mirror and screen in the carrying case. Picker X-Ray, 25 S. Broadway, White Plains, N.Y.

For more details circle #218 on mailing card.

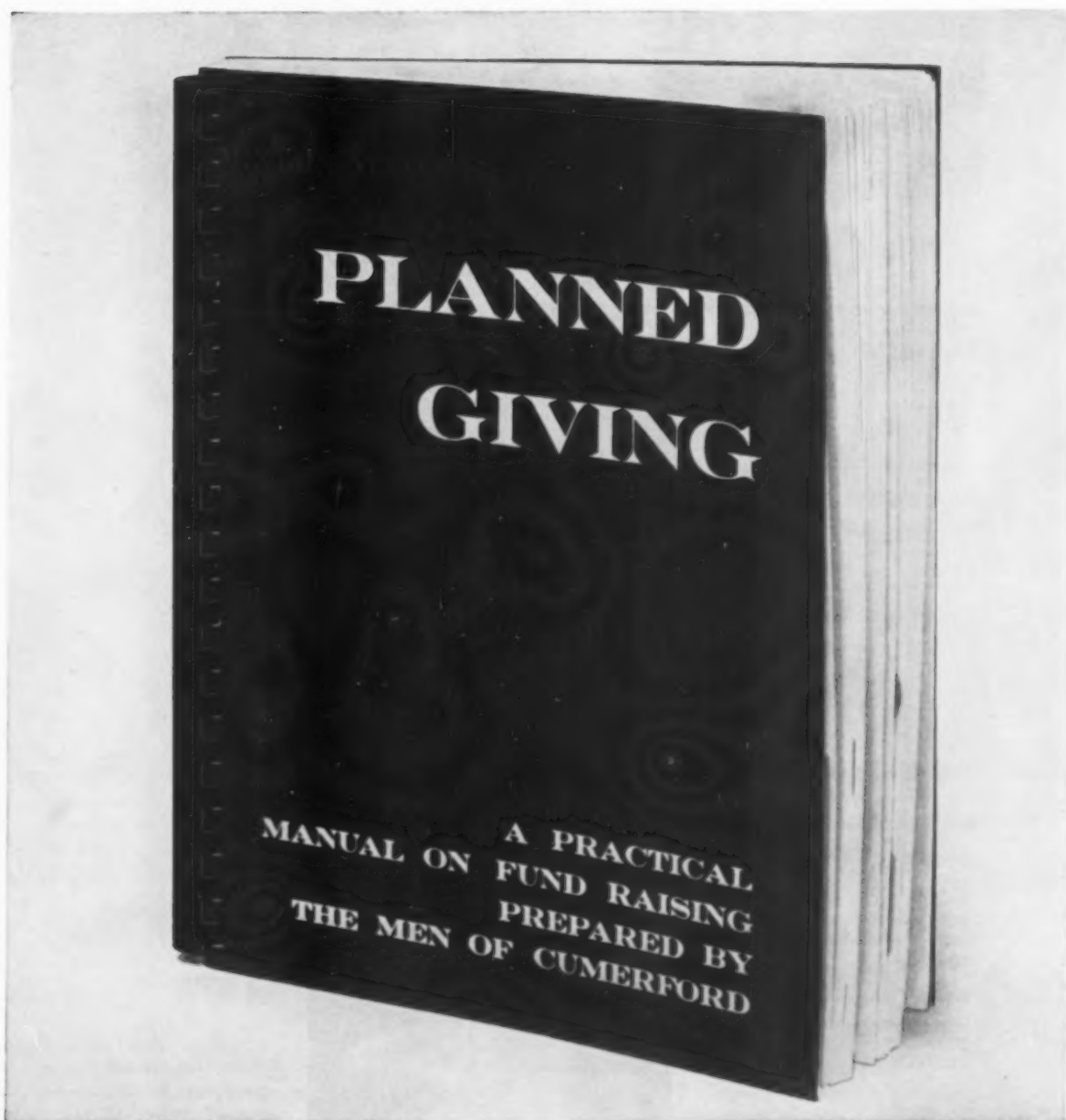
### Boiler-Burner Packages in Varied Sizes

Kewanee Scottie Jr. Boiler and Iron Fireman burners for gas, oil or combination gas-oil firing are now available in factory assembled packages ranging from 18 to 92 h.p. The units are completely integrated and available in eight sizes of high pressure packages and eight sizes of low pressure packages.

The new package units feature completely automatic forced-draft firing, requiring only a vent pipe. The units are available completely assembled, or the boiler may be shipped first and the burner at a later date. Kewanee Boiler Division, American-Standard, 101 Franklin St., Kewanee, Ill.

For more details circle #219 on mailing card.

(Continued on page 194)



THE MEN OF CUMERFORD PRESENT  
**THE FIRST DEFINITIVE TEXT  
ON FUND-RAISING**

The first comprehensive text on fund-raising is now off the press, published by the Men of Cumerford.

Over one thousand university or college presidents and hospital administrators have this volume in their personal libraries.

*Planned Giving* represents a

significant step forward in the field of fund-raising.

Every chapter has been written personally by a principal officer or senior staff director of Cumerford Incorporated.

This is another example of Cumerford service . . . a dedicated service bringing success to

scores of major fund-raising campaigns across the nation.

Why don't *you* talk to the Men at Cumerford about raising the money? Cumerford Incorporated, 912 Baltimore Street, Kansas City 5, Missouri. Telephone Baltimore 1-4686.

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safe!** **EMERGENCY  
OXYGEN and  
RESUSCITATION UNIT**  
by McKesson

A new, easily-portable, perfectly-balanced unit.  
Many outstanding safety and economy features.  
Uses either D or E size cylinders.

New, improved flow-valve graduated with adjustable zero position,  
always indicates approximate flow rate.  
Impossible to open control-valve more than one turn.

No danger of excessive flow-rate, should valve be left open  
when attaching full cylinder. Pin-indexed yoke  
precludes possibility of attaching improper gas.

For resuscitation, squeezing re-breathing bag  
forces oxygen into patient's lungs.

many  
other  
important  
features



Rubber feet prevent  
marring any highly  
polished surface.

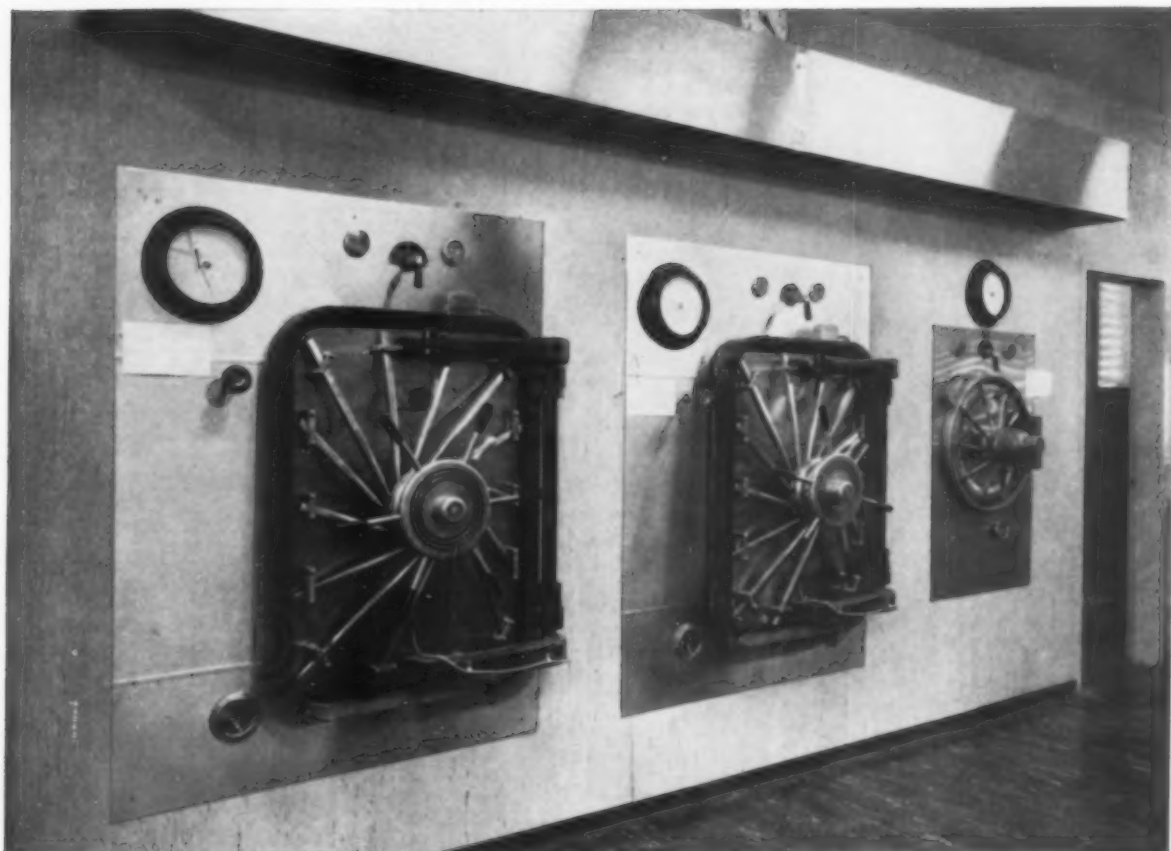
Weight of stand  
and valve complete,  
5¼ lbs.

**McKesson**

**EMERGENCY OXYGEN  
AND  
RESUSCITATION UNIT**

Contact your McKesson Dealer or write us today  
for complete information, specifications and prices.

**McKESSEON APPLIANCE COMPANY • TOLEDO 10, OHIO**



New Wilmot Castle bulk sterilizers recently installed in Central Supply, Booth Memorial Hospital, Flushing, N. Y.

The units are made of Nickel-clad steel. Circular instrument autoclave at right has door and cylinder of Monel.

Wilmot Castle tells...

## How Nickel-clad steel and Monel keep sterilizers working like new at Booth Memorial

Here's what Castle writes:

"Chambers of Castle bulk sterilizers are made of 1/4-inch Nickel-clad steel. The Nickel makes them impervious to corrosive saline solutions, steam, organic debris."

Nickel lining also makes for easy cleaning. Steel shell backs up the Nickel, boosts strength and resistance to high pressure.

"Steam jackets in Castle cylindrical units are made of solid, heavy-gauge Monel. Double-shell construction assures thorough preheating and drying of loads. Heat loss and condensation are minimized."

Monel® nickel-copper alloy

actually makes this improved construction possible. It withstands all the punishment of direct steam contact and quick temperature change.

So when you build or renovate, take a tip from Booth Memorial's sterilizing set-up. Make sure your sterilizers have the construction features that add to the life of the equipment, reduce maintenance. Wilmot Castle's Hospital Planning Service will help you select the type of units you need. Just write: Wilmot Castle Company, Rochester, N. Y.

\*Registered trademark

THE INTERNATIONAL NICKEL COMPANY, INC.

67 Wall Street



New York 5, N. Y.



Nickel-clad steel is a layer of pure nickel inseparably bonded to a heavier layer of steel. Monel is a homogeneous alloy consisting of about 2/3 nickel and 1/3 copper. Detailed information on these two useful engineering materials may be obtained by writing to Inco.

# INCO NICKEL ALLOYS

## WHAT'S NEW

### Pharmaceuticals

#### Chymar Aqueous

Chymar Aqueous is an aqueous solution of crystallized Chymotrypsin, ready to inject. Chymotrypsin, a highly refined enzyme extracted from beef pancreas, is used to reduce inflammation and speed the healing of bruises and hemorrhages. The new product is carried in sodium chloride solution and is stable for at least one year under refrigeration. It causes no local tissue reaction or pain on injection and can be given through a small gauge needle. **Armour Laboratories, Kankakee, Ill.**

For more details circle #220 on mailing card.

#### Neutrapen

Neutrapen is described as a specific for penicillin reactions. A preparation of purified injectable penicillinase, Neutrapen is intended for intramuscular or intravenous use in the management and treatment of allergic reactions to penicillin. It is indicated therapeutically in cases of allergic sensitivity to penicillin, except the immediate type of anaphylactic reaction. Prophylactically, it is administered concurrently when drugs and vaccines which contain small amounts of penicillin are given to patients known to be sensitive to penicillin and those who have a history of allergy. In clinical tests Neutrapen proved of definite value in reducing the severity and duration of both moderate and acute reactions to penicillin, acted within an hour, remained active in the body fluids

for several days, relieved itching promptly and proved safe and non-toxic. Neutrapen is supplied in single-dose vials containing 800,000 units of injectable penicillinase as lyophilized powder, available singly or in cartons of twelve. **SchenLabs Pharmaceuticals, Inc., 350 Fifth Ave., New York 1.**

For more details circle #221 on mailing card.

#### Diuril

Diuril is an orally effective nonmercurial agent with diuretic activity equivalent to that of the parenteral mercurials for initiation of diuresis and for prolonged maintenance of the edema-free state. It also provides basic therapy which improves and simplifies the management of hypertension. Diuril is well tolerated and is supplied in scored tablets of 250 and 500 mg. in bottles of 100 and 1000. **Merck Sharp & Dohme, West Point, Pa.**

For more details circle #222 on mailing card.

#### Liquamar 'Organon'

Liquamar 'Organon' is a potent coumarin derivative with high therapeutic action. Both experimentally and clinically Liquamar has shown marked and prolonged anticoagulant activity with short latent period following administration. It is a stable, easy to control oral anticoagulant, suitable for both short and long-term therapy. It is indicated in the prophylaxis and treatment of thrombosis and embolism. Liquamar is packaged in bottles of 100 and 1000 oral tablets. **Organon Inc., Orange, N.J.**

For more details circle #223 on mailing card.

### Literature and Services

• **Pyrex Laboratory Glassware** is the subject of the 350-page **Catalog LG-1** issued by Corning Glassworks, Laboratory Glassware Sales Dept., Corning, N.Y. More than 9000 items are described in the volume, including approximately 475 new pieces of color-coded Pyrex brand laboratory glassware. The book is divided into six sections covering Pyrex brand labware, Vycor brand silica labware, Pyrex brand fritted ware, Pyrex brand low actinic ware, Corning brand ware and custom made apparatus.

For more details circle #224 on mailing card.

• **"Systems Planning for Medical Color Television"** is the title of a portfolio of material on the subject prepared by the Radio Corporation of America, Broadcast and Television Equipment, Camden, N.J. Information on a new medical camera surgical illuminator is given, with modular plan for medical color TV, a special section on color TV for surgery, obstetrics, autopsy, laboratory and clinical demonstration and microscopy with data on TV viewing facilities and distribution systems. Floor plans, photographs and equipment information are all included in the comprehensive portfolio.

For more details circle #225 on mailing card.

• A new 20-page catalog on **Emergency Lighting Systems** for hospitals, schools and other institutions, is available from the Standard Electric Time Co., Springfield, Mass. Full descriptive information on the Standard Underwriters Laboratories approved systems is given in the new booklet which includes specifications on all components, fixtures and exit signs.

For more details circle #226 on mailing card.

• The line of A-F **"Panhandler" pot, pan and utensil washers** is described and illustrated in a new four-page catalog released by the Alvey-Ferguson Co., Cincinnati 9, Ohio. Complete specifications and dimensional blueprints of the pass-through and single-door models are given, with details of design features of each and layout diagrams for installation locations.

For more details circle #227 on mailing card.

• An informative booklet on **Pinkerton Service** is offered by Pinkerton's National Detective Agency, Inc., 154 Nassau St., New York 38. Excerpts are given from typical cases handled for hospitals, and problems encountered by hospitals are listed. Included is a list of hospitals using Pinkerton service.

For more details circle #228 on mailing card.

• A new non-technical booklet on vitamin B-12 is available from Merck & Co., Inc., Rahway, N.J. Entitled, **"Most Potent Vitamin,"** the booklet reviews the vast amount of recent clinical literature dealing with research findings on vitamin B-12.

For more details circle #229 on mailing card.

• **Erie Porcelain Enamel Curtain Wall and Veneer Panels** are the subject of a new 16-page catalog available from the Erie Enameling Co., Erie, Pa. Specifications, case histories and diagrammatic drawings of details are included.

For more details circle #230 on mailing card.

(Continued on page 196)

## SLIDE TO SAFETY...

In 63 actual fires, Potter Slide Fire Escapes evacuated everyone in plenty of time, without confusion or injury.

Adaptable to all types of occupancy and for installation on the interior as well as the exterior.

Return the coupon below for information and a representative if desired.



Spiral Type



Tubular Type

Tested and Listed as Standard by Underwriters' Laboratories, Inc.

### POTTER FIRE ESCAPE COMPANY, CHICAGO 45, ILL.

- ☐ Mail copy of new catalog.  
☐ Have fire escape engineer call with no obligation.

Submit estimate and details on ..... escapes.

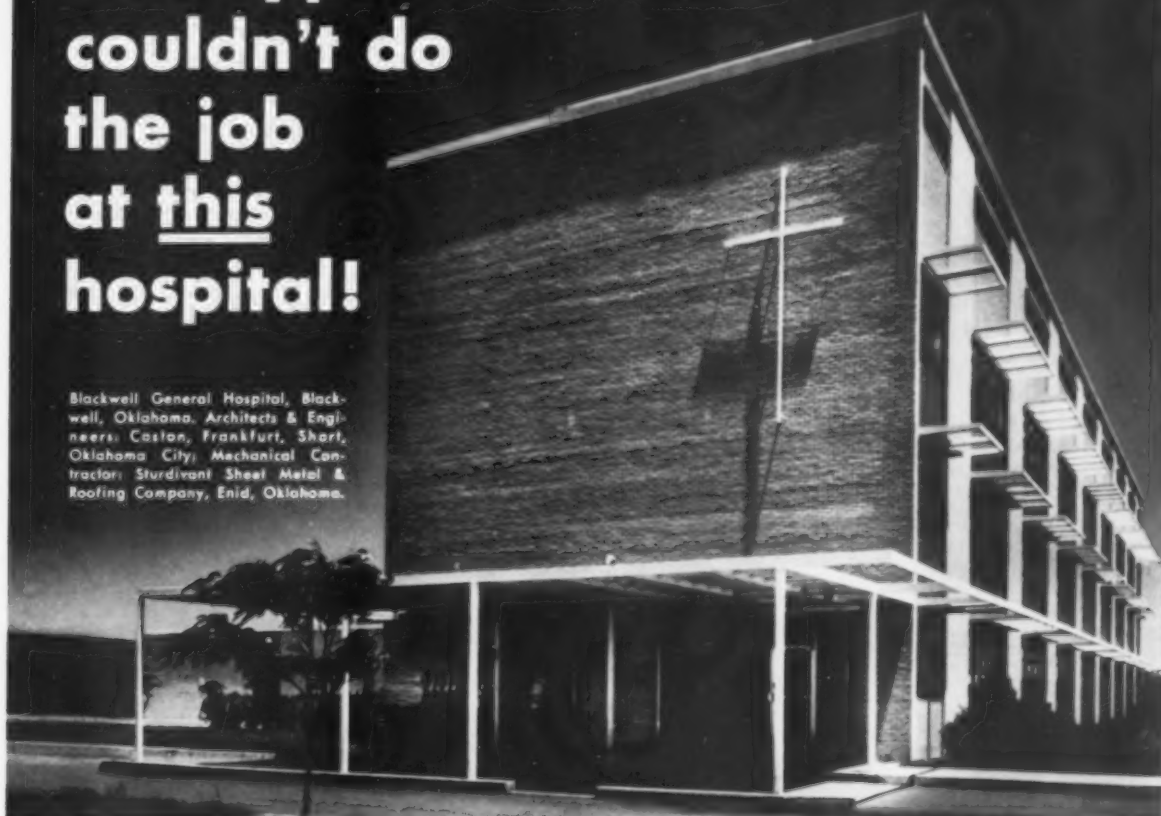
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Address.....

City.....

# One type of air filter couldn't do the job at this hospital!

Blackwell General Hospital, Blackwell, Oklahoma. Architects & Engineers: Costan, Frankfurt, Short, Oklahoma City; Mechanical Contractors: Sturdivant Steel Metal & Roofing Company, Enid, Oklahoma.



## Two distinctly different AAF filters keep air "hospital clean" at Blackwell General

No single type of air filter can meet all the clean-air needs of the modern hospital. Different needs demand different degrees of clean air. Blackwell General Hospital, Blackwell, Oklahoma, found two AAF filters—PL-24 and Multi-Duty—could give them exactly the kind of air they needed plus the maintenance characteristics they wanted.

The PL-24 is a unit filter featuring low-cost renewable filtering media. It's the world's

most efficient mechanical filter for ventilating and air-conditioning service. The Multi-Duty is a completely automatic viscous filter that requires no attention other than the periodic removal of sludge.

For complete product information on these filters, call your local American Air Filter representative or write direct for PL-24 Bulletin 230 and Multi-Duty Bulletin 241-E.



**American Air Filter**  
COMPANY, INC.

486 Central Avenue, Louisville 8, Kentucky  
American Air Filter of Canada, Ltd., Montreal, P. Q.

Air Filters and  
Precipitators



Illinois  
Heating Specialties

BETTER AIR IS OUR BUSINESS

Herman Nelson  
Console Heaters



AAF Dust Control  
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## WHAT'S NEW



### LIGHTING FIXTURES

of ORNAMENTAL BRONZE,  
WROUGHT IRON, ALUMINUM,  
STAINLESS STEEL to order.

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Estimates & Catalogs  
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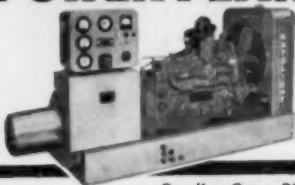


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### Best INSURANCE AGAINST POWER FAILURE...

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We all agree that it is just good business to insure against possible losses due to fire, wind or accident. Of course insurance can cover loss of tangible property or personal liability—but none is available to replace loss of time, inconvenience, personal discomfort and danger that power failure can cause.

For the best form of power failure "insurance" you can depend on Katolight Power Plants to keep your most important electrical equipment functioning whether it be for 3 minutes or for 3 years. Katolight can provide a unit to fit your hospital's exact needs.

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Katolight CORPORATION

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• "New Horizons in Food Service" is the subject of a newsletter published by W. H. Frick, Inc., Dispensator Div., 705 Citizens Blvd., Cleveland 14, Ohio. Illustrations of layouts showing central food service with various types of equipment are included in the bulletin which features "Better Hospital Food Service."

For more details circle #231 on mailing card.

• Owens-Illinois Glass Block is the subject of a 1958 catalog issued by Kimble Glass Co., a subsidiary of Owens-Illinois, Toledo 1, Ohio. The various decorative and functional patterns of glass block are described, including the solar-selecting block, and details of functional advantages of solar-selecting and light-directing designs are provided. The catalog also gives instructions and construction details for large and small sized panel installations in steel, wood and masonry framing. Dimensional tables as well as data on solar heat control, fuel savings, sound reduction and surface condensation are also included.

For more details circle #232 on mailing card.

• The use of soup by itself and combined with other foods for inexpensive but healthful and tasty dishes is the subject of an attractive new brochure released by the Heinz Food Service Center, H. J. Heinz Co., Pittsburgh 30, Pa. Entitled "For Profit Cook With Soup," the 48-page booklet contains many suggestions and quantity recipes for soups and garnishes and for meat, fish, poultry, meat substitute and vegetable dishes combined with soup. How tasty sauces can be quickly prepared from soups, and special sandwich recipes are included. Even dessert recipes using soup are given. The relatively inexpensive menu suggestions, with the saving in preparation time, make the recipes of even greater significance than their obvious taste appeal.

For more details circle #233 on mailing card.

• "Better Fruit Dishes With Low-Moisture Fruits" is the title of a handy 44-page quantity recipe book just released by the Vacu-Dry Co., 950-56th St., Oakland 8, Calif. Forty selected recipes for stewed fruits, sauces, pies, pastries, cakes, cookies, breads, puddings and other desserts are included, featuring Low-Moisture Fruits. Information on time-saving through use of Low Moisture Fruits, since preparation time is eliminated, as well as the savings in storage space is included.

For more details circle #234 on mailing card.

• Fifteen models of coolers, refrigerators, freezers and ice making equipment in the 1958 line of refrigeration equipment manufactured by Nor-Lake, Inc., Second and Elm, Hudson, Wis., are covered in a new catalog insert. The 4-page pamphlet covers representative models of the company's line.

For more details circle #235 on mailing card.

• The Beckman/Spinco Model R Paper Electrophoresis System is the subject of an 8-page catalog available from the Spinco Div., Beckman Instruments, Inc., Stanford Industrial Park, Palo Alto, Calif. Form SBR-2 also describes uses of paper electrophoresis in analyzing a variety of materials.

For more details circle #236 on mailing card.

• Finnell Floor-Maintenance Equipment and Supplies are the subject of a new illustrated 4-page folder available from Finnell System, Inc., 1400 East St., Elkhart, Ind. Packaging information, recommendations for using the equipment and supplies for institutional maintenance and new product data are included.

For more details circle #237 on mailing card.

• "Hospital Feeding Problems and Solutions" is the title of a cartoon-type booklet of questions and answers on matched paper food service for hospitals offered by the Dixie Cup Co., Easton, Pa. Printed in full color, the brochure shows paper food service in use. A slide sound film on its paper service is also available.

For more details circle #238 on mailing card.

• Administrators, and department heads responsible for food service, will find helpful information on canned foods in two new items offered by the American Can Co., 100 Park Ave., New York 17. They include a manual, "Purchase and Use of Canned Foods," designed for the use of the institutional meal planner and food buyer, and a set of labels showing can sizes, weight and cup capacity, and foods commonly packed in various sizes.

For more details circle #239 on mailing card.

• The new Sanymetal 1958 Catalog No. 95 of Toilet Compartments, Shower Stalls, Hospital Cubicles and Dressing Room Compartments contains a complete set of the 22 Sanymetal color samples. Released by The Sanymetal Products Co., 1693 Urbana Rd., Cleveland 12, Ohio, the catalog also gives standard specifications, descriptions of advanced construction features, and diagrams of mounting of stalls to floors, walls and so forth. Suggested floor layouts are also included.

For more details circle #240 on mailing card.

### Suppliers' News

Clarke Sanding Machine Co., Muskegon, Mich., manufacturer of floor finishing and maintenance equipment, announces the purchase of the Modern Power Sweeper Co., Azusa, Calif. All orders for both machines and service parts will be handled by Clarke, according to the announcement made by Ernest Cooper, President.

Royal Metal Mfg. Co., manufacturer of metal furniture, announces consolidation of its executive offices in its New York headquarters, One Park Ave., New York 16, and the moving of its showroom in Chicago to the Merchandise Mart as of February 1. The new moves were effected to give expanded customer service.

Wear-Ever Aluminum, Inc., is the new corporate name of the wholly-owned subsidiary of Aluminum Company of America formerly known as the Aluminum Cooking Utensil Co., Inc., and manufacturer of a complete line of aluminum cooking and clinical utensils. Located in New Kensington, Pa., the firm adopted Wear-Ever as a trade name in 1903 and the change in the corporate name is designed to eliminate duplication and confusion and to capitalize on the widespread recognition of the brand name.

The MODERN HOSPITAL



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The two cards below are detachable and are addressed to us. With this flap folded out you can turn through the magazine for the items on which you want further information.



When, in either an advertisement or "What's New" you locate the product, turn to the index to advertisements on the following page or to the index of "What's New" items (left) where you will find the key number for the item. Items advertised are listed alphabetically by manufacturer. "What's New" items are in Key Number order. Circle the corresponding key number on the card below for each item in which you are interested. The second card is for the use of someone else who may also want product data.



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